

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION			
Last Name:		First Name:	Middle Name:
Home Phone:		Cell Phone:	Work Phone:
Email Address:			
Mailing Address:		City:	State: Zip:
Date of Birth: / /		Gender:	
Occupation:			
Emergency Contact: Name:		Relationship:	Phone:
If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____			
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.			
DENTAL HISTORY & SYMPTOMS			
What is the reason for your visit today?			
Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?			
When was your last dental exam? / /		What was done at that appointment?	
When was the last time you had dental x-rays taken?			
Please mark an "X" in the box ONLY if this applies to you.			
Is it hard to open your mouth?		Have you ever had a serious injury to your head or mouth?	
Does it hurt to chew, bite or swallow?		If yes, please describe what happened and when it happened:	
Do your gums bleed when you brush or floss your teeth?		Have you ever had problems with dental treatment in the past?	
Have you ever had periodontal (gum) treatments like scaling and root planing?		If yes, please describe what happened:	
Do you have, or have you ever had, any sores or growths in your mouth?		Have you ever had a reaction to, or problem with, dental anesthesia?	
Do you clench or grind your teeth?		If yes, please describe what happened:	
Does your jaw click, pop or hurt?		Are you unhappy with your smile?	
Do you have earaches or neck pains?		If yes, why? Please mark all that apply:	
Does dental treatment make you nervous?		☐ The color of your teeth ☐ The shape of your teeth ☐ The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders?		☐ Other. Please describe:	
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			
MEDICATIONS & OTHER PRODUCTS/SUBSTANCES			
Please use an "X" to mark your answers to the following questions. Yes No ?			
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?			
If yes, what medication are you taking?			
Are you taking any medication to treat osteoporosis or Paget's disease?			
Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).			
If yes, what medication are you taking?			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			
Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).			
If yes, what medication are you taking? How many years have you been taking it?			
Are you taking hormonal replacements ?			
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?			
Do you use vaping products ?			
How many alcoholic beverages do you have per week?			
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?			
If yes, what substances? If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)?			
Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements ?			
If yes, please list them here and include information about how much and how often you use each one.			
Do you use GLP-1 Glucagon-Like Peptide-1 medication ?			
WOMEN ONLY: Are you:			
Taking birth control pills ?			
Pregnant? If yes, number of weeks:			
Nursing? If yes, number of weeks:			

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

Yes No ?

Aspirin ☐ ☐ ☐
Barbiturates, sedatives or sleeping pills ☐ ☐ ☐
Codeine or other narcotics ☐ ☐ ☐
Hay fever/seasonal allergies ☐ ☐ ☐
Iodine ☐ ☐ ☐
Latex (rubber) ☐ ☐ ☐
Local anesthetics ☐ ☐ ☐
Metals ☐ ☐ ☐
Penicillin or other antibiotics ☐ ☐ ☐

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim),
erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-
sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs),
dapson, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide
(Microzide) and furosemide (Lasix) ☐ ☐ ☐
Other ☐ ☐ ☐

Please describe any "Yes" answers and include information about your experience.

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

Yes No ?

Are you in good physical health? ☐ ☐ ☐
Are you currently being seen or treated by a physician? ☐ ☐ ☐
Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? ☐ ☐ ☐
Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐ ☐
Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)? ☐ ☐ ☐
Have you had a **heart valve replacement or heart surgery**? ☐ ☐ ☐
Have you had an **organ or bone marrow/stem cell transplant**? ☐ ☐ ☐
Have you traveled internationally within the last 30 days ☐ ☐ ☐
Have you had a fever (100.4°F or above) in the last 72 hours? ☐ ☐ ☐
If you answered yes to any of the above, please explain: _____

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Yes No ?

Yes No ?

Yes No ?

Heart (Cardiac) Health

Pacemaker/implanted defibrillator ☐ ☐ ☐
Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Congenital heart disease (CHD) ☐ ☐ ☐
 Unrepaired, cyanotic CHD ☐ ☐ ☐
 Repaired (completely) in last 6 months ☐ ☐ ☐
 Repaired CHD with residual defects ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Coronary artery disease ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur/rhythm disorder ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Stroke ☐ ☐ ☐

Breathing (Respiratory) Health

Asthma (COPD) ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐

Cancer

Type: _____
Date of diagnosis: _____
Chemotherapy: _____
Radiation treatment: _____

Blood (Circulatory) Health

Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
 If yes, date: _____
Hemophilia ☐ ☐ ☐
High or low blood pressure ☐ ☐ ☐

Brain (Neurological)/Mental Health

Anxiety ☐ ☐ ☐
Depression ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
Post-traumatic stress disorder ☐ ☐ ☐
Traumatic brain injury or concussion ☐ ☐ ☐

Autoimmune Disease

AIDS or HIV Infection ☐ ☐ ☐
Lupus ☐ ☐ ☐

Digestive Health

Gastrointestinal disease ☐ ☐ ☐
G.E. reflux/persistent heartburn (GERD) ☐ ☐ ☐
Stomach ulcers ☐ ☐ ☐

Eye (Vision) Health

Glaucoma ☐ ☐ ☐

Other

Arthritis ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes (type I or II) ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Frequent infections ☐ ☐ ☐
 Type of infection: _____
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Immune deficiency ☐ ☐ ☐
Kidney problems ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Sexually transmitted infection (STI) ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:

Yes No ?

Yes No ?

Yes No ?

had pain or tightness in the chest? ☐ ☐ ☐
coughed up blood or had a cough that
lasted longer than 3 weeks? ☐ ☐ ☐
been exposed to anyone with tuberculosis? ☐ ☐ ☐
had a rapid or irregular heart beat? ☐ ☐ ☐
found it hard to catch your breath? ☐ ☐ ☐
had a high fever (greater than 101.5°F) for
no reason? ☐ ☐ ☐
noticed a change in your vision? ☐ ☐ ☐
fainted for no reason? ☐ ☐ ☐
experienced vomiting, diarrhea, chills,
night sweats or bleeding? ☐ ☐ ☐
had migraines or severe headaches? ☐ ☐ ☐

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____

Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____



INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Whom may we Thank for referring you? _____



FINANCIAL POLICY

Thank you for choosing our office for your superior dental care. We are committed to providing you with the best possible care. We are pleased to discuss our service with you at any time. Your clear understanding of our financial and liability policies is important to our professional relationship. By signing below, you are in agreement with our policies.

Insurance

Insurance is a contract between you and your insurance company. We file claims on your behalf as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual & customary" charges, other than to supply factual information as necessary. You are responsible for a timely payment of your account. Not all necessary services are covered benefits in all contracts. The majority of carriers have a dental maximum that they will pay in any benefit year. Any fees not covered by your insurance company are due at the time of treatment. A dental benefit estimate will be made when services are provided.

Self Pay

If you do not have dental insurance, payment is expected in full at the time of your visit. If a payment plan is necessary, arrangements must be made prior to beginning any treatment. Any balances that extend over 90 days are subject to a monthly finance charge. We accept Cash and Checks, Visa, Mastercard, and Discover.

Cancellation Policy

A minimum of 24 hours notice is required for all cancellations. A charge will be made in the second violation of this policy.

Professional Liability

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested or had been recommended to me. I understand that I have the opportunity to ask any questions prior to any dental treatment.

I have read the above policies and fully understand this agreement.

Patient's Name

Date



No Show, or Missed Appointment Office Policy

When our staff books your appointment, we are setting aside a dedicated time slot just for you. Your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt.

We ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

Delaware Star Dental will charge \$75.00 for not providing us with at least 24 hours notice to cancel an appointment, or any missed scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Name

Date



PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of test, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Delaware Star Dental to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a message with anyone who answers the phone

Patient Name (PLEASE PRINT)

Date

Patient Signature



DELAWARE
Star Dental

PHOTOGRAPH RELEASE FORM

I, _____ give Delaware Star Dental the right to use photographs of me. I authorize Delaware Star Dental to use and publish images in print and/or electronically. I agree that Delaware Star Dental may use such photographs of me with _____ or without _____ my name and for any marketing purpose, including but not limited to publicity, illustration, advertising, brochures, office displays, and web content, etc.

I have read and understand the above:

Signature: _____

Print Name: _____

Date: _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY/SECURITY PRACTICES DELAWARE STAR DENTAL

**** You May Refuse to Sign This Acknowledgement ****

I, _____, have reviewed and understand this office Notice of privacy Practices. I agree with the policies and procedures outlined and have been given an opportunity to select alternative methods of communication/ payment and/or restricting communication.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, acknowledgement could not be obtained because:

- _____ **Individual refused to sign**
- _____ **Communications barriers prohibited obtaining the acknowledgement**
- _____ **An emergency situation prevented us from obtaining acknowledgement**
- _____ **Other (Please Specify)**

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