Medical History Form
Neil L. Starr, D.D.S., P.C.

Date: _____

Name_____Social Security #_____
Last First Middle

Residence Address_____
Address City Zip Code

Business Address_____
Address City Zip Code

Email Address _____

Home Phone _____ Work Phone_____ Cell Phone_____

Employed By_____

Occupation of Spouse_____

Date of Birth _____/_____/_____ Sex M F Height _____Weight_____Single_____Married_____

Contact in case of emergency:_____Relation:_____Home:_____Office:_____

Responsible for the account (if other than patient):_____
Name Relation

Please answer the following as completely as possible:
Reason for this visit?_____
Have you had any previous dental experiences worth noting?_____
Dentist's Name _____Referred by (we like to say "thank you")_____
Physician's Name_____
Physician's Phone_____
Name of your Dental Insurance Company_____
(Note: we are a non-participating practice and therefore do not accept any dental insurance. All payments are due as service is rendered)

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Health History:

1/ Are you in good health?----------Yes No
2/ Has there been any change in your general health within the past year?---------- Yes No
3/ Your last physical examination was on _____
4/ Are you currently under the care of a physician?----------Yes No
If so, what is the condition being treated?_____
5/ Have you had any serious illness, operation, or been hospitalized in the past 5 years?----------Yes No
If so, what was the illness or problem?_____
6/ Are you taking any medicine(s) including non-prescription medicine?---------- Yes No
If so, what medicine(s) are you taking? (circle those that apply)

Blood thinners:	Bone density medications/bisphosphonates:	Other:
Coumadin	Aredia	Tranquilizers
Plavix	Zometa	Sleeping pills
Aspirin	Fosamax	Anti depressants
Vitamin E	Actonel	Narcotics
Ginkgo Biloba	Other: (specify)_____	Herbal supplements/homeopathic remedies
Other: specify)_____		Other: (specify)_____

7/ Do you have any condition for which you require pre-medication for dental visits?---------- Yes No
8/ Do you have any joint replacement(s), i.e. hip or knee replacement?----------Yes No
9/ Do you have or have you had any of the following diseases or problems?
a. Damaged heart valves, artificial heart valves, mitral valve prolapse, heart murmur or rheumatic heart disease (circle)-Yes No

b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke?----(circle applicable conditions)---------- Yes No
   a) Do you have chest pain upon exertion?---------- Yes No
   b) Are you ever short of breath after mild exercise or when lying down?---------- Yes No
   c) Do your ankles swell?---------- Yes No
   d) Do you have inborn heart defects?---------- Yes No
   e) Do you have a cardiac pacemaker?---------- Yes No

c. Allergy---------- Yes No
d. Sinus trouble---------- Yes No
e. Asthma or hay fever---------- Yes No
f. Fainting spells or seizures---------- Yes No
g. Persistent diarrhea or recent weight loss---------- Yes No
h. Diabetes---------- Yes No
i. Hepatitis, jaundice or liver disease---------- Yes No
j. AIDS or HIV infection---------- Yes No
k. Thyroid problems---------- Yes No
l. Respiratory problems, emphysema, bronchitis, etc.---------- Yes No
m. Arthritis or painful swollen joints---------- Yes No
n. Stomach ulcer or hyperacidity---------- Yes No
o. Kidney trouble---------- Yes No
p. Tuberculosis---------- Yes No
q. Persistent cough or cough that produces blood---------- Yes No
r. Persistent swollen glands in neck---------- Yes No
s. Low blood pressure---------- Yes No
t. Low blood sugar---------- Yes No
u. Malignant hyperthermia ---------- Yes No
v. Sexually transmitted disease---------- Yes No
w. Epilepsy or other neurological disease---------- Yes No
x. Problems with mental health---------- Yes No
y. Cancer (if yes, list type)---------- Yes No
z. Problems of the immune system---------- Yes No
aa. Contagious diseases---------- Yes No

10/ Do you have recurring infections of any kind?---------- Yes No
11/ Delayed healing? (Medical or dental)---------- Yes No
12/ Frequent or severe headaches? ---------- Yes No
13/ Numbness or tingling in any part of your body? ---------- Yes No
14/ Have you had abnormal bleeding?---------- Yes No
15/ Have you ever required a blood transfusion? If so, when?---------- Yes No
16/ Do you have any blood disorder such as anemia?---------- Yes No
17/ Bruise easily? ---------- Yes No
18/ Have you ever had any treatment for a tumor or growth?---------- Yes No
19/ Are you allergic or have you had a reaction to:
   a) Local anesthetics---------- Yes No
   b) Penicillin ---------- Yes No
   c) Other antibiotics---------- Yes No
   d) Sulfa drugs---------- Yes No
   e) Barbiturates, tranquilizers, sedatives, or sleeping pills---------- Yes No
   f) Aspirin---------- Yes No
   g) Iodine---------- Yes No
   h) Codeine or other narcotics---------- Yes No
   i) Other medications---------- Yes No
   j) Latex---------- Yes No
20/ Do you have any disease, condition, or problem not listed above that you think I should know about?---------- Yes No
21/ Are you wearing contact lenses? ---------- Yes No

<u>Women:</u>

22/ Are you pregnant? ---------- Yes No
23/ Expected due date_____
24/ Do you have any problems associated with your menstrual period?---------- Yes No
25/ Are you nursing? ---------- Yes No
26/ Are you taking birth control pills? ---------- Yes No

Dental History:

27/ Do you presently have any pain, discomfort or impaired function related to your mouth? ---------- Yes No
If yes, please describe:_____

28/ Have you had any serious trouble associated with any previous dental treatment?---------- Yes No
If so, explain_____

29/ Do you have recurring infections of any kind?---------- Yes No

30/ Current infection in your mouth? ---------- Yes No
If yes, please describe: ----------

31/ Are you currently taking any antibiotics for the infection? If so, what? ---------- Yes No

32/ Do your gums ever bleed: If so, when? ---------- Yes No

33/ Any unhealed injuries, inflamed areas, growths, sore spots in your mouth? If so, where? ---------- Yes No

34/ Are any of your teeth tender when you chew: ---------- Yes No

35/ Are any of your teeth more sensitive to hot, cold, sweets, certain foods and/or drinks: (circle) ---------- Yes No

36/ Concerned about gum recession around any of your teeth? ---------- Yes No

37/ Have you ever received Periodontal treatment? ---------- Yes No
Scaling/root planning---------- Yes No
Gum surgery---------- Yes No
When did you go through Periodontal care?_____

38/ Concerned about the appearance of your teeth or mouth? ---------- Yes No

39/ Pain, clicking or popping of jaws when eating or pain near ears, difficulty in opening mouth?---------- Yes No

40/ Clench or grind your teeth? ---------- Yes No

41/ Are you wearing removable dental appliances? ---------- Yes No

42/ Interested in replacing lost teeth? ---------- Yes No

43/ Have you ever had Orthodontic treatment?---------- Yes No
With braces? ---------- Yes No
With removable appliances? ---------- Yes No
When did you go through Orthodontic treatment?_____

Additional information you feel we should know: _____
_____
_____
_____
_____

By signing below, I acknowledge that I have completed the above information to the best of my knowledge. Additionally, I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient (or Guardian) Date

For completion by the dentist.

Comments on patient interview concerning medical history: _____
_____

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Office Policies

I hereby authorize Dr. Neil Starr and his team to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association and that it is the sole responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Dr. Neil Starr and his team.

Signature of Patient (or Guardian) Date

Privacy of Information Policy:

I have been informed that this practice will make reasonable efforts to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release of any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Signature of Patient (or Guardian) Date

Cancellation Policy:

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definitive arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you, therefore, at lease 48 hours notice must be given if cancellation is absolutely necessary, otherwise usual fee charge will be made.

Signature of Patient (or Guardian) Date

Payment:

I understand that payment is due as service is rendered regardless of insurance coverage. (The office currently accepts payment by check, Visa, MasterCard, American Express, or Discover.)

Signature of Patient (or Guardian) Date

Notice of Privacy Practices: (you may refuse to sign this Acknowledgement)

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.
The above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient (or Guardian) Date

For Office Use Only

- □ Individual refuses to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (please specify):_____
- □ _____
- □ _____