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4 STAR DENTAL
JACQUELINE BLASKO DMD
SNAHEL PRAJAPATI DMD

Welcome to our Practice! Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

DATE:_____

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____ SS# _____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name_____ DOB_____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from 4 Star Dental

Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

Employer: _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Walk-in □ Direct Mail □ Web Search □ Practice Website □ Event

□ Another Physician/Provider _____

FOR OFFICE USE ONLY:

*Patient Name*_____

*Patient #*_____

AUTHORIZATION, RELEASE, and AGREEMENT to Pay for Services Rendered

☐ **Do Not Release Information**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/ or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient or parent/ guardian if minor _____ Date_____

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

INSURANCE INFORMATION

Commercial Insurance

Primary Insurance_____ ID _____ Group#: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID: _____ Group#: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Medicaid

Medicaid Plan _____ ID# _____

Medicare Advantage Plan_____ ID#_____

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please feel free to ask. We are always happy to help.

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PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

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Adult Dental History Form

Do you have any of the following diseases or problems:	Yes	No
Active tuberculosis	☐	☐
Persistent cough greater than a 3-week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐
	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist

Dental Information

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?	☐	☐	Are you currently experiencing any pain or discomfort?	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	Do you participate in active recreational activities?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you have ear aches or neck pain?	☐	☐
Is your mouth dry?	☐	☐	Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Do you brux or grind your teeth?	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Is your home water supply fluoridated?	☐	☐	Do you wear dentures or partials?	☐	☐
Do you drink bottled or filtered water? If yes, how often? (circle one) DAILY WEEKLY OCCASIONALLY	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam: _____

Date of last Dental X-ray: _____

What is the reason for your visit today? _____

_____

How do you feel about your smile? _____

_____

Medical Information

	Yes	No		Yes	No
Are you under the care of a physician?	☐	☐	Do you use controlled substances (drugs)?	☐	☐
Have you had a serious illness, operation, or been hospitalized in the last 5 years?	☐	☐	Do you use tobacco (smoking, snuff, chew, bids)?	☐	☐
Are you in good health?	☐	☐	Do you drink alcoholic beverages?	☐	☐
Have there been any changes to your general health within the last year?	☐	☐			

	Yes	No
Are you taking or have you recently taken any prescription or over the counter medicines? If so please list all including vitamins, natural or herbal preparations and/ or diet supplements _____ _____ _____	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, have you had any complications? _____ _____	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began: _____	☐	☐

	Yes	No
WOMEN Are you pregnant? Number of weeks: _____	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	☐	☐

Allergies- Are you allergic to or have you had a reaction to:

- ☐ Aspirin
- ☐ Barbiturates, Sedatives, Sleeping pills
- ☐ Codeine
- ☐ Food
- ☐ Hay Fever
- ☐ Iodine
- ☐ Latex (rubber)
- ☐ Local Anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other _____

Please indicate if you have or have had any of the following diseases or problems

- ☐ Abnormal bleeding
- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer/ Chemotherapy
- ☐ Cardiovascular Disease
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ Damaged Heart Valves
- ☐ Diabetes 1 or 2
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Fainting Spells or Seizures
- ☐ G.E Reflux/ Heartburn
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice or Liver Disease
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Malnutrition
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Persistent swollen glands in neck
- ☐ Previous Infective Endocarditis
- ☐ Recurrent Infections
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ S.T. I
- ☐ Migraines
- ☐ Rapid weight loss
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Systematic Lupus Erythematosus
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Patient Signature _____ *Date* _____