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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.

4 STAR DENTAL
JACQUELINE BLASKO DMD
SNAHEL PRAJAPATI DMD

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: _____

Child Dental History Form

4 STAR DENTAL
JACQUELINE BLASKO DMD
SNAHEL PRAJAPATI DMD

Patient's Name (FIRST LAST)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (CITY STATE ZIP CODE)		
Phone (Home Cell)	Sex M F	

Have you (the parent/guardian) or the patient had any of the following diseases or problems?	Yes	No
Active tuberculosis?	☐	☐
Persistent cough greater than a three-week period?	☐	☐
Cough that produces blood?	☐	☐

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

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV/ AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/ Drug use
☐ Asthma	☐ Chicken pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding Disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other
☐ Bones/ Joints	☐ Ear aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Child's History

			Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ _____	2	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3	☐	☐
4.	Has the child ever had a serious illness? If yes, when? Please describe: _____ _____	4	☐	☐
5.	Has the child ever been hospitalized?	5	☐	☐
6.	Does the child have any speech difficulties?	6	☐	☐
7.	Is the child physically, mentally, or emotionally impaired?	7	☐	☐
8.	Does the child experience excessive bleeding when cut?	8	☐	☐

			Yes	No
9.	Is the child currently being treated for any illnesses?	9	❑	❑
10.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit. Date: _____	10	❑	❑
11.	Has the child had any problem with dental treatment in the past?	11	❑	❑
12.	Has the child ever had dental radiographs (x-rays) exposed?	12	❑	❑
13.	Has the child ever suffered any injuries to the mouth, head or teeth?	13	❑	❑
14.	Has the child had any problems with the eruption or shedding of teeth	14	❑	❑
15.	What type of water does your child drink? City water Well water Bottled water Filtered water	15	❑	❑
16.	Does the child take fluoride supplements?	16	❑	❑
17.	Is fluoride toothpaste used?	17	❑	❑
18.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	18		
19.	Does the child suck his/her thumb, fingers or pacifier?	19	❑	❑
20.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____	20		
21.	Does the child participate in recreational activities?	21	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____

Date _____