TEXAS ★ STAR DENTAL

MEDICAL AND DENTAL HISTORY

Today's Date:_____ Age:_____
Your Name:_____ Date of Birth:_____
Physicians Name:_____ Physicians Phone #_____
When was your last visit to your physician?_____
When was you last complete physical?_____
Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____
_____

DO YOU HAVE A LATEX ALLERGY?_____
Please List all DRUGS/ MEDICATIONS you currently take: Include prescription and over-the-counter:_____
_____
_____

PLEASE TELL US IF YOU HAVE ANY OF THE FOLLOWING:

- ❑ Frequent Headaches
- ❑ Irregular Heartbeat
- ❑ High Blood Pressure
- ❑ Rheumatic Heart Disease
- ❑ Artificial Heart Valve(s)
- ❑ Mitral Valve Prolapse
- ❑ Heart Attack _____ Year
- ❑ Pacemaker
- ❑ Heart Murmur
- ❑ Arthritis
- ❑ Artificial Knee, Hip, Joint, Pins
- ❑ Stroke
- ❑ Abnormal Bleeding
- ❑ Glaucoma
- ❑ Fainting Spells
- ❑ Anemia
- ❑ Asthma
- ❑ HIV or AIDS
- ❑ Shortness of Breath
- ❑ Respiratory Disease
- ❑ Hay Fever
- ❑ Sinus Problems
- ❑ Shingles
- ❑ Tuberculosis/ TB
- ❑ Hemophilia
- ❑ Blood Transfusion
- ❑ Radiation Treatment
- ❑ Psychiatric Problems
- ❑ Chemical Dependency
- ❑ Diabetes
- ❑ Liver Problems
- ❑ Hepatitis
- ❑ Herpes
- ❑ Fever Blisters
- ❑ Ulcers/ Colitis
- ❑ Venereal Disease
- ❑ Thyroid Problems
- ❑ Cancer/ Tumors
- ❑ Epilepsy/ Seizures
- ❑ Kidney Problems
- ❑ Pregnant __ Months
- ❑ Other _____ _____ _____

Please describe the reason for your visit today: _____
_____
When was your last dental check up? _____ Did you have x-rays taken?_____
Who is your previous dentist?_____ May we request records?_____

PLEASE INDICATE IF YOU HAVE EVER NOTICED OR HAS ANY DENTIST OR HYGIENIST EVER SAID THAT YOU HAVE ANY OF THE FOLLOWING:

Have gum disease	_____	Lip or cheek biting	_____
Grind or clench your teeth	_____	Loose or broken fillings	_____
Clicking or popping jaw	_____	Had a "deep cleaning" in the past	_____
Jaw pain or tiredness	_____	Sores, blisters or growths	_____
Pain around ear	_____	Bad breath	_____
Dry mouth	_____	Bleeding gums	_____
Sensitivity to Hot/ Cold	_____	Sensitivity to sweets	_____

Do you use dental floss? _____ _____ How often? _____ times a day/ week.
How often do you brush? _____ times a day.
Would you like whiter teeth? _____
Do you like the appearance of your smile? _____
What would you change? _____
_____
Have you ever been told that you require antibiotics before dental treatment? _____
Do you have anxiety about dental treatment? _____ Rate on a scale 1-10 (10-highest) _____
Patient Signature_____ Dr. Signature _____

TEXAS ★ STAR DENTAL

WELCOME

PERSONAL INFORMATION

Patient Name _____ Birth Date _____

What name would you preferred to be called _____

Social Security no. _____

Mailing Address _____ Apt/Unit #_____

City _____ State _____ Zip Code _____

Gender ____ Male _____ Female

Family Status _____ Married _____ Single _____ Child _____ Other _____

Email Address _____

Phone: Cell _____ Home_____

Work _____Other _____

If the patient is a child, please provide the first and last name of parent/ guardian:

_____

Emergency Contact _____

Relationship to patient _____

Phone #_____

Do you have dental insurance coverage? YES NO

Dental Insurance Company Name: _____

Insured's Name:_____

Insured's ID # _____

Insured's Date of Birth: _____

Who may we thank for referring you to our practice?

- ❑ Brochure
- ❑ Website
- ❑ Insurance Co.
- ❑ Magazine
- ❑ Coupon
- ❑ Patient/ Friend
- ❑ Other_____

Please let us know the person that referred you so we may say "Thank You"!

_____

Acknowledgements and Signature

I acknowledge that the information I gave in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature_____

Date _____

I understand that I will be required to pay my ESTIMATED portion of Dr. Austin's fees at the time of service. Unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of ANY and ALL services rendered, regardless of insurance reimbursement.

Signature _____

Date _____

TEXAS ★ STAR DENTAL

CONFIDENTAL INFORMATION/ FINANCIAL GUIDELINE AGREEMENT

Please check below where you want to receive correspondences about appointments, billing and insurance inquiries, or dental healthcare questions.

Cell#_____ Work#_____ Home# _____ Other #_____Email address_____

May confidential; messages be left on the voicemail or Email given above? YES_____ NO_____

If you do not have a voicemail, may a confidential message be left with a secretary, personal assistant or family member? YES_____ NO_____

Thank you for choosing our dental office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

PLEASE NOTE: Returned checks will be subject to an additional $30.00 fee. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

There will also be a $30.00 charge if we do not receive a 24 hour cancellation notice.

Do you have Insurance?

- As a courtesy to you we help process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine that amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received for your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time the services are performed unless arrangements are made.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

I have read, understand and accept the terms of the above outlined guidelines for insurance handling and financial commitment that I may occur. After 60 days of the treatment date, I authorize Lauren Austin DDS to bill my credit card to pay any remaining balances left on may account.

Credit Card Type _____ Credit Card Number _____

Expiration Date _____Security Code _____

Signature of patient, or guardian (responsible party):

_____ **Date**_____

Informed Consent Photographs

I understand that photographs, x-rays and other records may be made during the course of my examination, treatment, and follow-up-care. I give permission for such items to be used for purposes of research, education, or publication on professional journals.

Signature _____

Date_____