

STAR DENTAL SYSTEMS, INC.

Patient's Name: _____ Social Security Number: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone _____ Cell Phone _____
Email Address: _____
Emergency Contact Person: _____ Relationship: _____ Phone: _____
So that we may express our gratitude, please tell us who referred you to our office: _____

DENTAL HISTORY

Why are you here today? _____

Would you describe your dental health as good:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you have regular dental visits?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Last check up date: _____		
Do you think you have active decay or gum disease?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do your gums ever bleed?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you nervous about having dental treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you difficult to "get numb" for dental treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you like your smile?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you want to keep your teeth?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

MEDICAL CONDITIONS

Are you allergic to any medications? If so, please list _____
Are you allergic to latex? _____
Do you take birth control medication? _____ **If so, antibiotics may cancel out your birth control medications.**
Do you take **Fosamax, Zometa, Acredia, Actonel or Boniva** for Osteoporosis or Cancer treatment? _____
Do you have Osteoporosis? _____
Do you have any artificial body parts? _____
Do you have COPD? _____
Have you had X-ray and/or Cobalt therapy? _____
Do you wish to talk privately about any problem? _____

HOW DO YOU PLAN TO PAY FOR YOUR DENTAL CARE?

_____ Credit Card _____ Debit Card _____ Cash _____ CareCredit _____ Insurance

INSURANCE INFORMATION

Insurance company name _____
Subscriber's Name (if other than yourself) _____
Subscriber's Social Security Number _____
Subscriber's Date of Birth _____
Subscriber's Employer _____
Your relationship to subscriber _____

Patient Signature _____ **Date:** _____