WELCOME

About You

Today's Date: _____ Email Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female

Birth date: ____/____/_____ Age:____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____

When are the best times to reach you? _____ How did you find us? _____

Employer: _____ Occupation: _____

Employer's Address: _____
Street /PO Box City State Zip

_____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Member #:_____ Group # (if applicable): _____

Insurance Co Phone Number (from back of ID card): _____ Policy Holder's Name:_____

Policy Holder's Social Security #: _____ Policy Holder's Birthdate:_____/_____/_____

Relation:_____ Policy Holder's Employer:_____

Employer's Address: _____
Street /PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Member #:_____ Group # (if applicable): _____

Insurance Co Phone Number (from back of ID card): _____ Policy Holder's Name:_____

Policy Holder's Social Security #: _____ Policy Holder's Birthdate:_____/_____/_____

Relation:_____ Policy Holder's Employer:_____

Employer's Address: _____
Street /PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ❑ Yes ❑ No
Do you require antibiotics before dental treatment? ❑ Yes ❑ No
Your current dental health is: ❑ Good ❑ Fair ❑ Poor
Do you floss daily? ❑ Yes ❑ No
Do you brush daily? ❑ Yes ❑ No
Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft
Do your gums ever bleed? ❑ Yes ❑ No
Do your gums ever itch? ❑ Yes ❑ No
Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else?
_____
Do you have mobility in your teeth? ❑ Yes ❑ No
Do you still have your wisdom teeth? ❑ Yes ❑ No
Previous/Present Dentist: _____ Last Visit Date: _____
Would you like fresher breath? ❑ Yes ❑ No
Would you like whiter teeth? ❑ Yes ❑ No
Are you happy with the way your smile looks? ❑ Yes ❑ No
If not, what would you change?
_____

Medical History

Do you have a primary care physician? ❑ Yes ❑ No
Physician's Name:_____
Address: _____
_____
Phone #: (_____)_____ Date of Last Visit: _____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: _____
Do you smoke or use tobacco in any form? ❑ Yes ❑ No
Have you ever taken Phen-Fenm Redux or Pondimin? ❑ Yes ❑ No
For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Unsure ❑ Yes ❑ No
Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N	Abnormal Bleeding	Y N	Difficulty Breathing	Y N	Hepatitis	Y N	Scarlet Fever
Y N	Alcohol Abuse	Y N	Drug Abuse	Y N	Herpes	Y N	Seizures
Y N	Anemia	Y N	Emphysema	Y N	High Blood Pressure	Y N	Shingles
Y N	Arthritis	Y N	Epilepsy	Y N	HIV+ / AIDS	Y N	Sickle Cell Disease
Y N	Artificial Bones/Joints	Y N	Ever Hospitalized?	Y N	Kidney Problems	Y N	Sinus Problems
Y N	Artificial Valves	Y N	Fainting Spells	Y N	Liver Disease	Y N	Steroid Therapy
Y N	Asthma	Y N	Fever Blisters	Y N	Low Blood Pressure	Y N	Stroke
Y N	Blood Transfusion	Y N	Glaucoma	Y N	Lupus	Y N	Thyroid Problems
Y N	Cancer	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tonsillitis
Y N	Chemotherapy	Y N	Headaches	Y N	Pacemaker	Y N	Tuberculosis (TB)
Y N	Chicken Pox	Y N	Heart Attack	Y N	Persistent Cough	Y N	Ulcers
Y N	Colitis	Y N	Heart Murmur	Y N	Psychiatric Problems	Y N	Venereal Disease
Y N	Congenital Heart Defect	Y N	Heart Surgery	Y N	Radiation Treatment		
Y N	Diabetes	Y N	Hemophilia	Y N	Rheumatic Fever		

Please list any serious medical condition(s) that you have experienced: _____
Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____
_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Sedatives
Y N	Barbiturates	Y N	Jewelry / Metals	Y N	Sulfa Drugs
Y N	Codeine	Y N	Latex	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Penicillin	Y N	Other

Please list anything additional that causes allergic reactions: _____
_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

THE STAR DENTAL GROUP
Compassionate Care, Technical Brilliance

Phone: 732-563-0066
Fax: 732-563-0266
Info@thestardentalgroup.com

Authorization to Email Protected Health Information

Communication of protected health information via unsecured email communication containing sensitive health information can be sent between The Star Dental Group and the patient.

Authorize email communication

☐ I authorize the The Star Dental Group Staff to email me regarding the course of my dental care, treatment and diagnostic test results as well as with questions regarding my account status.

Patient's email address (please print): _____
Signature required at bottom of page

Change email address

☐ I am changing the email address to be used for communications with The Star Dental Group.

New email address (please print): _____
Signature required at bottom of page

Discontinue email communication

☐ I no longer wish to communicate via email. **Signature required at bottom of page**

- I understand that any email transmission between my provider and me/the patient will become part of my medical record. These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to The Star Dental Group I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this Authorization.
- I understand that this authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment if I refuse to sign this Authorization.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.
- I understand that this Authorization will not expire unless revoked in writing.

I have read and agree that email messages may include protected health information about me / the patient, whenever necessary.

_____ _____
Patient's signature Date

_____ _____
Patient's Printed Name Date of Birth

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General Consent Form

Patient name: _____

Please read this form before you sign it.

Medical History Information
Please understand that it is important that you give all information about your medical history to your provider. It is important that you inform us of any medicines that you are taking each time that you come to an appointment, as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotics or with other medications. Please be sure to provide us with a list of any allergies.

Restorations (Fillings and Crowns)
I understand that care must be exercised in chewing on fillings and crowns until directed by the doctor or staff to avoid breakage or soft tissue damage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay or the condition of remaining tooth structure. I understand that sensitivity may occur after a newly placed filling or crown. I also have been informed that in some cases, root canal treatment may be required following a restoration. I realize that a large filling may not be a good long term solution and may lead to tooth breakage that will require further treatment.

Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy may be necessary following routine restorative procedures. Also, a filling may be extended to cover additional surfaces if deemed necessary due to decay or fractures not evident upon the original examination. I give my permission to the dentist to make any/all changes and additions as necessary after consultation.

Complications
Although rare, complications can occur from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is transient but on infrequent occasion, may be permanent), reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure. The risks of complications from medications used/prescribed with general dental treatment include, but are not limited to, drowsiness, lack of awareness and coordination, nausea, allergic reactions, etc. (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs).

Initial _____

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It is not advisable to operate any motor vehicle or hazardous device while experiencing side effects of the medications we may prescribe. Antibiotics are known to decrease the effectiveness of oral contraceptives, so it is advised that other contraceptive measures be taken during the administration of antibiotics.

X-Rays and Photos

Modern digital dental x-ray equipment exposes patients to a very low dose of radiation. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays that allow us to do a thorough exam for each patient. All patients 18 years and older will receive a full mouth series of intra-oral x-rays and/or a panorex every 5 years. All patients will also receive bitewing x-rays every 1-2 years depending on overall dental risk. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e.: broken tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the diagnosis and/or treatment on an emergency basis. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Requests for records/x-rays

By law we are required to keep a patient's original x-rays and record in this office.
Original x-rays or records will NOT be released. The patient or a designated person may request copies of their x-rays or record. We require a minimum of 5 days' notice to copy x-rays or record.

Specialty Referral and/or Second Opinion

General dentists perform the majority of all dental treatment today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases we may have to refer certain procedures out to a specialist. We would be happy to offer you the names of specialists in order for you to have a second opinion and/or have actual treatment performed by a specialist.

Initial _____

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I hereby authorize the dental staff of The Star Dental Group to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to allow The Star Dental Group to take any necessary x-rays and perform an examination on me today.

Patient or Parent/Guardian
Signature: _____
Date: _____

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ASSIGNMENT OF DENTAL BENEFITS

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to The Star Dental Group.

This authorization shall remain in effect until rescinded in writing.

_____

Print Name

_____ _____

Patient or Guardian Signature Date

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I have received a copy of this office's Notice of Privacy Practices.

Print Name:

_____

Signature:

_____

Date:

_____

A copy of this office's Notice of Privacy Practices can be viewed and downloaded at www.thestardentalgroup.com

You may refuse to sign this acknowledgment

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify below)