Please take a few minutes to answer the following questions
So we can better assist you with your dental needs:

Patient Information

Name________________________________ Date of Birth____/____/____ Soc. Sec.______________
Last First In.

Address:________________________________ Home Phone______________________

________________________________ Cell Phone______________________
City Zip-Code

Gender: M☐ F☐ Single☐ Married☐ Long Term Partner☐ Divorced☐ Widowed☐ Separated☐

Employer________________________________ Employer Phone______________________

Employer Address________________________________ Occupation______________________

How did you find out about our office________________________________

In case of emergency contact(other than parent)________________________________
Name Phone Number

Email Address:________________________________

Information required if patient is under 18

Father's Name________________________________ Mother's Name______________________

Date of Birth____/____/____ Soc.Sec.______________ Date of Birth____/____/____ Soc.Sec.______________

Occupation________________________________ Occupation______________________

Employer's Name________________________________ Employer's Name______________________

Work Phone________________________________ Work Phone______________________

Insurance Information

Primary Insurance Name______________________ Secondary Insurance Name______________________

Subscriber's Name______________________ Subscriber's Name______________________

Date of Birth____/____/____ Soc.Sec.______________ Date of Birth____/____/____ Soc.Sec.______________

Assignment and Release

I hereby authorize payment directly to FIVE STAR DENTISTRY for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party________________________________ Date______________

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? ____
   Physician's Name ____ Phone ____
   Address ____ City ____ ___State____Zip____
2. Have you taken any medication or drugs during the past two years? .... Yes No
3. Have you ever taken diet drugs such as Phen-Fen? .... Yes No
   If yes, please list name and dosage ____
4. Are you taking any medication, drugs or pills now ? .... Yes No
   If yes, please list name and dosage ____
5. Are you aware of having an allergic (or adverse reaction) to any medication or substance? .... Yes No
   If yes, please list ____
6. Have you been a patient in the hospital during the past five years? .... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no' to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Side Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizure	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? .... Yes No
9. Have you lost or gained more than 10 pounds in the past year? .... Yes No
10. Do you have or have you had any disease, condition or problem not listed? .... Yes No
    If yes, please list: ____
11. **Women** ,-Are you: **Pregnant ?** Yes,___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature ____ Date ____

HISTORY REVIEW

Dentist Signature ____ Date ____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? ______________________________

____

Date of Last Dental Visit__________ **Last Dental Cleaning** __________ **Last Full Mouth X-rays**__________

What was done at your last dental visit? ______________________________

____

Previous Dentist's Name ______________________________

Address ______________________________ State ______ Zip ______

Telephone______________________________

How often do you have dental examinations?______________________________

How often do you brush your teeth? __________ How often do you floss? __________

What other dental aids do you use? (Interplak, toothpick, etc.) ______________________________

Do you have any dental problems now? Yes No

If yes, please describe: ______________________________

Are any of your teeth sensitive to:

Hot or cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? ______________

Do you:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tabacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause __________

____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neckaches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe______________

____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe ______________________________

____

____

(Please complete other side)

FIVE STAR DENTISTRY

INFORMED CONSENT AND INSURANCE AUTHORIZATION

Name:____

1: Work to be done: I understand that I am having the following treatment done: Filling(s)_____, Bridge(s)_____, Crown(s)_____, Extraction(s)_____, Root Canal Therapy_____, Other_____.

2: Drugs and Medication: I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction), Inflammation of a vein (thrombophlebitis) from intravenous and intramuscular injections, injury to and stiffening of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication, or drugs that may have been administered to me for my care. I understand that failure to take medications prescribed to me in the manner prescribed may offer risks of continued or aggravated infection, pain and **potential resistance to effective treatment of my condition**.

3: 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 the initial examination. The most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any and all changes as necessary.

4: Removal of Teeth: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the dentist to remove the following teeth_______and any others necessary for reasons stated in paragraph 3. I understand removing teeth does not always remove all of the infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, fractured jaw, loss of feeling on the lips, tongue and surrounding tissue (**Paresthesia**) that can last for an indefinite period of time. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

5: Crowns, Bridges, Veneers and Bonding: I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth or materials. I further understand that I may be wearing temporary restorations which may come off easily and that I must be careful to ensure that they are kept in tact until the permanent restorations are completed. I realize that the final opportunity to make changes to my restorations including shape, size, fit and color will be before final cementation. It has been explained to me that in very few cases, cosmetic procedures may result in the need further treatment, which cannot be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6: Dentures- Complete or Partial: I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including, looseness, soreness, and possible breakage. I realize the final opportunity to make changes to the completed appliance will be in the wax try in phase. I understand that most dentures require adjustments after delivery and a permanent relining approximately 3 to 12 months after placement. The cost for this procedure is **not** included in the initial denture fee.

7: Endodontic Treatment (Root Canal Therapy): I understand that there is no guarantee that root canal therapy will save my tooth and that complications may occur from the treatment that may require further treatment from a specialist or loss of the tooth.

8: Periodontal Disease: I understand that I have a serious condition which causes tissue inflammation and bone loss and that if untreated it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including but not limited to gum surgery, periodontal cleanings and extractions. I understand that undertaking any dental procedures may have future adverse effects on my periodontal condition.

I understand that dentistry is not an exact science and that therefore reputable practitioner cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I acknowledge and understand the post-operative instructions that have been given to me including additional office visits if necessary. In signing this form, I authorize this office to bill me and receive payment from any third party payor on my behalf for services rendered.

Signature:____ **Date**________________________

Dentist:____ **Witness:**________________________

FIVE STAR DENTISTRY
CONSENTIMIENTO DENTAL Y ASEGURAMIENTO DE AUTORIZACION

Nombre:______________________________

1. **Trabajo para hacer:** Yo entiendo que me van a hacer el siguiente trabajo: Relleno(s)_____, Puente(s)______, Corona(s)______, Extracione(s)_______, Endodoncia(s)_______, Remover Dientes Impactados_______,Otro_______.

2. **Drogas, medicamentos y sedantes:** Yo estoy informado y entiendo que los antibioticos y otros medicamentos me pueden causar una reacion de algergia severa y dolor, inflamación de la vena intravenosa y de injeciones intracusculares, daño y dureza del cuello y músculos faciales. Puede causar mareos, perdida de conocimiento y coordinación que pueden aumentar con el uso de alcohol y drogas. Yo entiendo completamente y estoy de acuerdo que no puedo operar vehículos y máquinas peligrosas por lomenos 12 horas después o hasta que me encuentre completamente recuperado de lo efectos de la anestesia y medicamentos que me hayan dado. Yo entiendo que Si no mc tomo los medicamentos en la forma que mc los recetaron mi situación de salud puede agravar provocándome infección y dolor.

3. **Cambios en Tratamiento Dental:** Yo entiendo que durante mi tratamiento puede ser necesario cambiar o agregar procedimientos, porque a veces el dentista encuentra cosas que no encontró al principio del examen. Por ejemplo, Si el dentista esta haciendo Un relleno y l caries entro al nervio del diente es necesario cambiar el tratamiento a endodoncia en ese dientes, doy mi permiso al dentista a aser en mi toc el trabajo que sea necesario.

4. **Scar Dientes:** **Otras alternativas han** sido explicados ami por ejemplo: endodoncia, coronas y cirujia de pierda de hueso y yo autoriz al dentista a remover los siguientes dientes__________yo entiendo que cuando sacan el diente no va a quitar toda la infección. Es posible que se necesite mas tratamiento. Yo entiendo que pueden pasar problemas cuando sacan dientes como dolor, hinchazón, extendimiento de infección, pérdida de sensación en labios y lengua, dientes y tejido al rededor que pueden durar un tiempo indifinido y fractura en la quijada. Yo entiendo que puede ser que en el futuro necesite tratamiento por un especialista o tal vez hospitalización si resultan complicaciones durante o después dcl tratamiento el costo de este será mi responsabilidad.

5. **Coronas** y **Puentes:** Yo entiendo que hay veces que no es posible combinar el color artificial con el color natural dcl diente. Yo entiendc que tengo que usar una corona temporal y es posible que se mc caiga fácil. Tengo que tener cuidado asta que mc pongan la corona o puente antes de cementar. Me han explicado que havido alguna veces que se tiene que hacer un tratamiento dc endodoncia en cual no se puede predecir con anticipación. Entiendo que el procedimiento cosmético puede afectar el diente alrededor y que requiere modificación de limpieza diaria.

6. **Dentadura Completa o Parcial:** Yo entiendo que dentaduras completas o parciales son artificiales hechas de plástico, metal o porcelana. Los problemas de usar estos instrumentos me han sido explicados y incluyen aflojamiento, dolor y la posibilidad que se quiebre. Yo entiendo q: la ultima oportunidad que tengo para hacer cambios en mi dentadura incluyendo forma, tamaño y color va ser cuando los dientes estén en cera. Yo entiendo que la moyoria de las dentaduras requieren de ser ajustadas aproximadamente cada tres a doce meses posiblemente. El costo de es procedimiento no esta incluido en el costo initial de su visita.

7. **Tratamiento de Endodoncia (Limpieza de Canales):** Reconosco que no hay garantia que la limpieza del canal salve mi diente y qu puede haber complicaciones que pueden occurrir en el tratamiento y en ocaciones objetos de metas seran cementados en el diente o extendido atraves del canal lo cual no necesariamente afecta resultados satisfactorios del tratamiento.

8. **Perdida de Hueso y Encia:** Yo entiendo que tengo una condición muy seria, causando inflamacion en el hueso y encia y que puede conducir ala perdida dcl diente. Me han dado una alternativa explicándome que puedo tener una cirujia en la encia, remplazamiento o extraciones. Yo entiendo que bajo cualquier procedimiento dental en el futuro puede tener efectos adversos en mi condición de endodonica.

Yo admito que no hay garantia o aseguramiento que han sido hecho por alguien respecto el tratamiento dental que doy autorización. Y entiendo que ci dentista es un individual doctor y tiene la responsabilidad individual para el cuidado dental dado a mi. Yo también entiend que no hay otro dentista que el dentista asiendo el tratamiento es responsable de mi tratamiento dental. Y reconosco que el recibo y entiend las instrucción que me han dado y la cita para regresar. Yo al firmar, doy autorización para que la oficina mande instruciones a la compañí de seguros por servicios resibidos en esta oficina.

Firma ______________________________ Fecha ______________

Firma del Dentista: ______________________________ **Testigo** ______________

MISSED APPOINTMENT & UNPAID BALANCES POLICY

Purpose: To notify patients of a possible financial penalty for failure to cancel a scheduled appointment. Missed appointments have an impact on Dr Alas schedule and can also pose a dental risk to the patient. When a patient does not show up for an appointment on short notice, we will make a note on the dental records.

Failure to give 24-hour notice of cancellation of an appointment or not Showing up for an appointment or re-scheduling can result in a charge of $45.oo on your account. This charge cannot be billed to the insurance or medical and it will be your responsibility. Failure to pay a no show fee will be Treated according to our policy of unpaid balances.

Dental care will not be withheld for a dental emergency. Not showing up for three appointments can result in the patient discharged from the practice.

If past due accounts are sent to collections, patient then is responsible for collections charges that could be up to 40% of the delinquent amount.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY

____

Patients name (print)

____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice
(patient/ parent or guardian if minor)
of Privacy Practices.

____
(Please Print Patient Name)

____
(Signature)

____
(Date)

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

____

____

____

____