Starr General Dentistry

6400 Cobbs Drive Suite 500 Waco, Texas 76710 (254)776-7410 (254)776-6207(fax)

Medical History and Health Information

Patient Name: _____ Preferred Name: _____

Patient DOB: _____

Date of Last Dental Visit: _____ **Date of last cleaning:** _____ **Date of last x-rays:** _____

Reason for this visit: _____

Preferred Doctor: **Taylor Starr** **Martin Starr**

Name of the person or office referring you to our practice: _____

List of Current Medications: _____ _____ _____

_____ _____ _____ _____

Medication Allergies and Adverse Reactions:

- ☐ Latex or Rubber Products
- ☐ Local Anesthetic
- ☐ Sulfa Drugs
- ☐ Penicillin or other antibiotics (Indicate which) _____
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Barbiturates or sleeping pills

Other: _____

Have you *ever* had any of the following? Please *check* those that apply:

- ☐ AIDS
- ☐ Immune Disorder
- ☐ Allergies
- ☐ Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints Which_____ Date_____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bleeding tendency
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Growths/ Tumors
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Stints Date: _____
- ☐ Hepatitis: type? _____
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment to head, neck, or jaws
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ TMJ
- ☐ Tuberculosis

Women:

- ☐ Taking Birth Control
- ☐ Pregnancy or Nursing Due: _____

Warning Signs of Periodontal (Gum) Disease

1. Do you have gums that bleed during tooth brushing?
   ☐ Yes ☐ No
2. Are your gums red, swollen, or tender?
   ☐ Yes ☐ No
3. Do you have gums that have pulled away from your teeth?
   ☐ Yes ☐ No
4. Do you have persistent bad breath?
   ☐ Yes ☐ No
5. Do you have pus between the teeth and gums?
   ☐ Yes ☐ No
6. Are your teeth loose or separating?
   ☐ Yes ☐ No
7. Have you noticed a change in the way your teeth fit together when you bite?
   ☐ Yes ☐ No
8. Have you noticed a change in the fit of your partial dentures?
   ☐ Yes ☐ No

Over ➡

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- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you wearing a removable dental appliance? ☐ Yes ☐ No
- Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how much/often?: _____
- Is there any history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?
  ☐ Yes ☐ No If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? Other conditions you think the doctor should know about? ☐ Yes ☐ No If yes, please explain:_____
- Do you wish to talk with the doctor privately about anything? ☐ Yes ☐ No

Acknowledgement of Receipt of Notice of Privacy Practices

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

Signature:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:**_____

Signature of patient, parent or guardian

BELOW TO BE COMPLETED BY THE DOCTOR

Comments on patient interview concerning medical history:

_____

_____

_____

Significant findings form questionnaire or oral interview:

_____

_____

_____

Dental management considerations:

_____

_____

Date_____ Doctor's Signature_____