



STAR CARE DENTAL
 1102 Baltimore Pike
 Crossroads Center, Suite 203
 Glen Mills PA 19342

WELCOME

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for Yourself Your Child

Patient Full Name _____ Social Security # _____

Birth Date _____ Age _____ Male Female _____

Address _____ City _____ State _____ Zip _____

Full Time Student _____ Yes No School Name _____

Employer _____ Occupation _____

Previous Dentist _____ Previous Dentist Phone _____

Current Physician _____ Current Physician Phone _____

Whom may we thank for referring you _____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____ Social Security # _____

Are you Single Married Divorced Widowed

Birth Date _____ Age _____ Male Female _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Home Phone _____ Work Phone _____

4) INSURANCE INFORMATION

Dental Coverage Yes No

Insured's Name _____ Relation _____

Insured's Social Security # _____ Birth Date _____

Insurance Group # _____ Insurance Policy # _____

Insurance Co. Name _____ Insurance Co Phone _____

Please continue on next page.

5.) Dental History

Why have you come to the dentist today? _____
Do you require antibiotics before dental treatment? Yes ___ No ___
Are you currently in pain? Yes ___ No ___
Do your gums ever bleed? Yes ___ No ___
Have you ever had difficulties associated with any previous dental work? Yes ___ No ___
Do you or have you ever experienced pain in your jaw joint (TMJ/TMD)? Yes ___ No ___
Have your tonsils or adenoids been removed? Yes ___ No ___
Do you floss on a regular basis? Yes ___ No ___

6.) Medical History

Do you consider yourself in good medical health? Yes ___ No ___
Are you taking any medications? Yes ___ No ___
If so, please list here _____
Are you allergic to any medications? Yes ___ No ___
If so, please list here _____
(Women) Are you currently pregnant? Yes ___ No ___
If so, how many weeks? _____
(Women) Are you nursing? Yes ___ No ___
(Women) Are you taking birth control? Yes ___ No ___
Are you allergic to dental anesthetics? Yes ___ No ___
Are you allergic to erythromycin? Yes ___ No ___
Are you allergic to latex or rubber product? Yes ___ No ___
Are you allergic to metals? Yes ___ No ___
Are you allergic to penicillin? Yes ___ No ___
Are you allergic to tetracycline? Yes ___ No ___

Have you ever had any of the following medical problems?

Abnormal bleeding	Yes ___ No ___	Hepatitis	Yes ___ No ___
Alcohol/ Drug abuse	Yes ___ No ___	Herpes/Fever blisters	Yes ___ No ___
Anemia	Yes ___ No ___	High blood pressure	Yes ___ No ___
Arthritis	Yes ___ No ___	HIV/AIDS	Yes ___ No ___
Asthma	Yes ___ No ___	Kidney Problems	Yes ___ No ___
Cancer	Yes ___ No ___	Liver Problems	Yes ___ No ___
Diabetes	Yes ___ No ___	Low blood pressure	Yes ___ No ___
Difficulty breathing	Yes ___ No ___	Pacemaker	Yes ___ No ___
Emphysema	Yes ___ No ___	Rheumatic Fever	Yes ___ No ___
Epilepsy	Yes ___ No ___	Seizures	Yes ___ No ___
Fainting spells	Yes ___ No ___	Shingles	Yes ___ No ___
Frequent Headaches	Yes ___ No ___	Sickle Cell Disease	Yes ___ No ___
Glaucoma	Yes ___ No ___	Sinus Problems	Yes ___ No ___
Hay Fever	Yes ___ No ___	Stroke	Yes ___ No ___
Heart Attack	Yes ___ No ___	Thyroid Problems	Yes ___ No ___
Heart murmur	Yes ___ No ___	Tuberculosis	Yes ___ No ___
Heart Surgery	Yes ___ No ___	Ulcers	Yes ___ No ___
Hemophilia	Yes ___ No ___	Venereal Disease	Yes ___ No ___

4.) Acknowledgement & Authorization

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____