HEALTH HISTORY

Date _____ **Patient Name** _____ **Name you wish to be called** _____
Physical Address _____ **Home Phone** _____
City _____ **State** _____ **Zip Code** _____ **Work Phone** _____
Mailing Address _____ **Cell Phone** _____
City _____ **State** _____ **Zip Code** _____
Best Time and Place to Reach You Live and In Person _____
Sex: M F Age _____ **Birthdate** _____ **Single Married Widowed Separated Divorced**
Patient SS # _____ **Occupation** _____ **Employer** _____
Employer Address _____ **Employer Phone** _____
Spouse Name _____ **Birthdate** _____ **SS#** _____
Occupation _____ **Spouse's Employer** _____

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IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)
Name _____ **Relationship to you** _____
Address and Phone Number of Emergency Contact Person _____
Whom may we thank for referring you? _____
Who is responsible for this account? _____ **Relationship to patient** _____

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Insurance Company _____ **Group #** _____
Is patient covered by additional insurance? Yes ☐ No ☐ Subscriber's name _____
Subscriber's Birthdate _____ **Subscriber's SS#** _____ **Relationship to Patient** _____
Insurance company _____ **Group #** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with (N/A if none) _____ **and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or Not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

_____ _____ _____
Responsible Party Signature **Relationship** **Date**

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____ **City/State** _____
Date of last dental visit _____ **Date of last dental X-rays** _____
Please check Yes ☐ or No ☐ to indicate if you have had any of the following:

Bad breath	**Yes ☐**	**No ☐**	**Bleeding gums**	**Yes ☐**	**No ☐**	**Blisters on lips or mouth**	**Yes ☐**	**No ☐**
Burning sensation on tongue	**Yes ☐**	**No ☐**	**Chew on one side of mouth**	**Yes ☐**	**No ☐**	**Cigarette, pipe or cigar smoking**	**Yes ☐**	**No ☐**
Clicking or popping Jaw	**Yes ☐**	**No ☐**	**Dry mouth**	**Yes ☐**	**No ☐**	**Fingernail biting**	**Yes ☐**	**No ☐**
Do you or have you ever experienced pain/discomfort in your jaw joint?	**Yes ☐**	**No ☐**	**Food collection between teeth**			**Chewing tobacco**	**Yes ☐**	**No ☐**
Food collection tender	**Yes ☐**	**No ☐**	**Foreign objects**	**Yes ☐**	**No ☐**	**Grinding teeth**	**Yes ☐**	**No ☐**
Periodontal	**Yes ☐**	**No ☐**	**Jaw pain or tiredness**	**Yes ☐**	**No ☐**	**Lip or cheek biting**	**Yes ☐**	**No ☐**
Loose teeth or broken fillings	**Yes ☐**	**No ☐**	**Mouth breathing**	**Yes ☐**	**No ☐**	**Orthodontic treatment**	**Yes ☐**	**No ☐**
Pain around ear	**Yes ☐**	**No ☐**	**Sensitivity to cold treatment**	**Yes ☐**	**No ☐**	**Gums swollen or Sensitivity when biting**	**Yes ☐**	**No ☐**
Sensitivity to heat	**Yes ☐**	**No ☐**	**Sensitivity to sweets**	**Yes ☐**	**No ☐**	**Do you like your smile**	**Yes ☐**	**No ☐**
Sores or growths in your mouth	**Yes ☐**	**No ☐**	**How often do you floss?** _____			**Type of bristles**	**Hard**	**Medium Soft**
			How often do you brush? _____			**Have you ever had a serious or difficult problem associated with previous dental work?**	**Yes ☐**	**No ☐**
						Do you snore?	Yes []	No []
						Are you interested in whitening?	Yes []	No []
						Are you interested in Invisalign?	Yes []	No []

How did you hear about us? _____

7 West 7th Street, Ste. 1
Cincinnati, OH 45202
513-241-STAR || info@sevenstardental.com
www.SevenStarDental.com

MEDICAL HISTORY

Physician's Name _____ **Date of last visit** _____

Please check Yes ☐ or No ☐ to indicate if you have had any of the following:

AIDS	**Yes ☐**	**No ☐**	**Epilepsy**	**Yes ☐**	**No ☐**	**Psychiatric Care**	**Yes ☐**	**No ☐**
Anemia	**Yes ☐**	**No ☐**	**Fainting or dizziness**	**Yes ☐**	**No ☐**	**Radiation Treatment**	**Yes ☐**	**No ☐**
Arthritis, Rheumatism	**Yes ☐**	**No ☐**	**Glaucoma**	**Yes ☐**	**No ☐**	**Respiratory Disease**	**Yes ☐**	**No ☐**
			Headaches	**Yes ☐**	**No ☐**	**Rheumatic Fever**	**Yes ☐**	**No ☐**
Artificial heart valves	**Yes ☐**	**No ☐**	**Heart Murmur**	**Yes ☐**	**No ☐**	**Scarlet Fever**	**Yes ☐**	**No ☐**
			Heart Problems	**Yes ☐**	**No ☐**	**Shortness of Breath**	**Yes ☐**	**No ☐**
Artificial Joints	**Yes ☐**	**No ☐**	**Hepatitis**	**Yes ☐**	**No ☐**	**Sinus Trouble**	**Yes ☐**	**No ☐**
Asthma	**Yes ☐**	**No ☐**	**Type** _____			**Skin Rash**	**Yes ☐**	**No ☐**
Back Problems	**Yes ☐**	**No ☐**	**Herpes**	**Yes ☐**	**No ☐**	**Special Diet**	**Yes ☐**	**No ☐**
Bleeding abnormally (with extractions or surgery)	**Yes ☐**	**No ☐**	**High Blood Pressure**	**Yes ☐**	**No ☐**	**Stroke**	**Yes ☐**	**No ☐**
			Meds: _____			**Swelling of Feet or ankles**	**Yes ☐**	**No ☐**
	Yes ☐	**No ☐**	**HIV Positive**	**Yes ☐**	**No ☐**			
Blood Disease	**Yes ☐**	**No ☐**	**Jaundice**	**Yes ☐**	**No ☐**	**Swollen Neck Glands**	**Yes ☐**	**No ☐**
Cancer	**Yes ☐**	**No ☐**	**Jaw Pain**	**Yes ☐**	**No ☐**	**Thyroid Problems**	**Yes ☐**	**No ☐**
Chemical dependency	**Yes ☐**	**No ☐**	**Joint replacement**	**Yes ☐**	**No ☐**	**Tonsillitis**	**Yes ☐**	**No ☐**
Chemotherapy	**Yes ☐**	**No ☐**	**Kidney Disease**	**Yes ☐**	**No ☐**	**Tuberculosis**	**Yes ☐**	**No ☐**
Circulatory problems	**Yes ☐**	**No ☐**	**Liver Disease**	**Yes ☐**	**No ☐**	**Tumor or growth on Head or Neck**	**Yes ☐**	**No ☐**
			Low Blood Pressure	**Yes ☐**	**No ☐**			
Congenital Heart Lesions	**Yes ☐**	**No ☐**	**Mitral Valve Prolapse**	**Yes ☐**	**No ☐**	**Ulcer**	**Yes ☐**	**No ☐**
			Nervous Problems	**Yes ☐**	**No ☐**	**Venereal Disease**	**Yes ☐**	**No ☐**
Cortisone treatments	**Yes ☐**	**No ☐**	**Pacemaker**	**Yes ☐**	**No ☐**	**Weight Loss, unexplained**	**Yes ☐**	**No ☐**
			Women:					
Cough, Persistent or bloody	**Yes ☐**	**No ☐**	**Are you pregnant?**	**Yes ☐**	**No ☐**	**Any hospital stays**	**Yes ☐**	**No ☐**
			Due date _____			**Explain** _____		
Diabetes	**Yes ☐**	**No ☐**	**Are you nursing?**	**Yes ☐**	**No ☐**	_____		
Do you wear Contact lenses?	**Yes ☐**	**No ☐**	**Are you taking birth control pills?**	**Yes ☐**	**No ☐**	_____		
						_____		

****

MEDICATIONS

Please list medications you are currently taking:

_____

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES (Check if applies)

Aspirin [ ]
Barbiturates (sleeping pills) [ ]
Codeine [ ]
Latex [ ]
Other _____

Local Anesthetic [ ]
Penicillin [ ]
Sulfa [ ]
Iodine [ ]

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.
I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.
I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Patient's Signature **Date**
(I have read, agree to, and understand the statements listed above)

_____ _____

Doctor's Signature **Date**

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