Starley family dental

Date: ______________

HEALTH HISTORY UPDATE

Patient Name ________________________________ Date of Birth ________________

Address ________________________________ City/State/Zip ________________

Email ________________________________ Phone ________________

Employer ______________________ Any changes to your insurance? __________ (If yes, please present front desk with new insurance information)

Have you experienced an adverse reaction during/in conjunction with a medical/dental procedure? Y / N

Primary Care Physicians Name ______________________ Phone ______________

Have you had any serious illnesses or operations? If yes, describe ______________________

Have you ever had a blood transfusion? If yes, give approximate dates ______________________

Are you taking any blood thinners? If yes, list name and dose ______________________

Are you taking any medication for Osteoporosis? If yes, list ______________________

Women (please circle): Are you pregnant? Y / N Nursing? Y / N Currently using any form of birth control? Y / N

Check whether you have had any of the following:

- ☐ Aids/HIV positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ **Artificial heart valves**
- ☐ **Artificial joints**
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia/Abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw Pain
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ **Latex** allergy
- ☐ **Metal** allergy
- ☐ Other material allergies, please list: ______________
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/heart surgery
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Rheumatic/Scarlet fever
- ☐ Respiratory disease
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Surgical implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Ulcer/Colitis

Are you currently taking any medications? If Yes, list all:

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____
____
____
____
____

Do you have any drug allergies? If yes, list all:

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____
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To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ ______________

Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ______________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

See Other Side

Starley family dental

FINANCIAL POLICY

Thank you for choosing Starley Family Dental as your dental care provider. Our office maintains that every patient is entitled to the highest quality of dental care that can be provided. Your health and well-being are our primary concern. We appreciate the consideration you must give to the cost of your care. We welcome discussion concerning services and fees prior to treatment.

Your estimated portion for treatment is due at the time of service.

Insured Patients: Your insurance is a contract between you and your insurance company. All dental plans are not the same and do not cover the same services. It is your responsibility to know and comply with the terms of your insurance contract. In the event your dental plan determines a service to "not be covered" or payment is denied due to failure to comply with the terms of the contract, you will be responsible for the complete charge. As a courtesy, we will file your claim on the day of service.

Non-insured Patients: If there is no insurance coverage, full payment is due at the time of service.

I understand that the responsibility for payment of all dental services provided by Dr. John R. Starley, Dr. Nathan J. Starley and Dr. Spencer J. Starley for me and my dependents is mine. I understand I am responsible for my dental insurance co-payments, payment percentages, and procedures not covered. The information on my patient registration form is accurate.

A monthly finance charge at a fixed rate of 1.5% per month/18% annum of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. Should my account be turned over for collection, I, the undersigned agree to pay the remaining balance, and all costs to collect the debt, including, but not limited to, interest in the amount of 18% annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

I grant my permission to you or your assignee to telephone me to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies.

Print name of Patient /Responsible Party____

Signature____Date:________________

INFORMED CONSENT

I authorize Dr. John R. Starley, Dr. Nathan J. Starley or Dr. Spencer J. Starley and/or such associates or assistants as he may designate to perform those procedures as may deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents, including those related to restorative, palliative, therapeutic or surgical treatments.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature____Date:________________