TOP ★ STAR
PROSTHODONTICS

PATIENT INFORMATION

NAME_____ TODAY'S DATE_____

ADDRESS_____

CITY _____STATE _____ZIP_____

HOME PHONE_____ CELL PHONE_____

E-MAIL _____.

SOCIAL SECURITY # _____.

DL# _____AGE _____BIRTHDATE _____.

PRIMARY LANGUAGE_____.

EMPLOYMENT

OCCUPATION _____EMPLOYER_____

STATE _____STATE _____ZIP_____ PHONE_____

RESPONSIBLE PARTY

NAME _____TODAY'S DATE_____

ADDRESS _____.

CITY _____STATE_____ZIP _____.

HOME PHONE _____CELL PHONE_____.

PERSON TO CONTACT FOR EMERGENCY

NAME_____RELATIONSHIP_____.

PHONE _____.

PRIMARY CARE PHYSICIAN PHONE_____.

1-I Certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.

2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.

3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

4. By signing below, I authorize that you/your agents/third parties who are assisting on our behalf may send me a email and text message appointment reminders, marketing material, and account updates, including electronic billing statements.

SIGNATURE OF RESPONSIBLE PARTY _____DATE_____

HEALTH HISTORY FORM

Patient's Name _____ **Date of Birth** _____/_____/_____

Gender _____ **Height** _____ **Weight** _____ **Today's Date** _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor

Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No

If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No

If yes, please describe_____

Have you had any adverse effects from dental treatment? Yes / No

If yes, please describe_____

Date of last dental visit?_____

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes / No

If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?_____

If yes, please describe_____

Name of physician_____ Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No

If yes, please describe_____

Have you ever had surgery? Yes / No

If yes, please describe_____

_____

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type_____

Diagnosis date_____

Treatments_____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No

If yes, please describe_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes?	Yes / No	Relationship_____	Heart disease?	Yes / No	Relationship_____
Lung disease?	Yes / No	Relationship_____	Bleeding problems?	Yes / No	Relationship_____
Cancer?	Yes / No	Relationship_____			

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No

If yes, please describe_____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose

Medication and dose

Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No **Do you use:**

If yes, for how long? Alcohol? Yes / No If yes, how often per week?

Have you ever sought professional care or been hospitalized for: Marijuana? Yes / No If yes, how often per week?

_____

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

Substance abuse	Yes / No
Emotional disorders	Yes / No
Alcoholism	Yes / No

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____

Printed name of patient, parent, guardian/Relationship

For office staff use - HEALTH HISTORY REVIEW

Date	Comments	Doctor's Signature

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

PATIENT _____

Patient Acknowledgment of Notice of Privacy Practices

Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

I,_____ acknowledge that you have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me

_____ _____

Patient's signature Date

_____

Print legal Guardian's Name (if patient is a minor)

_____

Legal Guardian's signature

For office use only:

☐ Patient refused a copy of the Notice of Privacy Practices (NPPs).
☐ Patient refused to sign Acknowledgment of NPPs.

_____ _____

Print Name (office staff). Date

_____

Signature

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FINANCIAL AGREEMENT:

Thank you for choosing TSP as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

General:

We will file insurance on your behalf, please note you are responsible for the balance due on your account for any and all professional services rendered. This includes but is not limited to dental fees, surgical procedures, test, office procedures, medications and any other services not directly provided by the dentist.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not party to that contract. Here at TSP there are only a few insurances that we participate with in the office. For those insurances, please note that TSP will bill the insurance for you. However, as the patient you are responsible for all of your copays, deductibles, and non covered fees.
Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion. For any patients that are out of network, TSP will file your insurance claim as a courtesy, however, your estimated portion is due in (initial) full at time of service.

48 HOUR CANCELLATION & NO SHOW POLICY:

Thank you for choosing Top Star Prosthodontics and allowing us to provide you with outstanding care. If you miss your appointment, or fail to cancel your appointment with less than 48 business hours notice, you will be charged a non-refundable fee of $100.00 This policy is in place out of respect to our Doctor and our patients. Cancellations with less than 48 business hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent our Doctors from providing care to other patients.

TREATMENT:
When the patient is restoring implants from TSP, the pt will be responsible to put the minimum of **30%** down of the whole treatment plan before any treatment is to begin. The 30% must be paid at the time the patient is securing the appointment. Please understand that the **30%** is non-refundable. Please know that special supplies, office fees, administrative fees, must be delivered in order to complete your restoration, and these parts are unique to you as the patient.
I have read, understand and agree to the terms and conditions of this Financial Agreement.

_____ _____

Signature Date

_____ _____

Witness Date

AUTHORIZATION TO RELEASE PHOTOGRAPHY OR DIGITAL IMAGES

Patient Name_____
Last First MI Maiden or Other Name

Date of birth _____/_____/_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

I grant Dr._____ and his/her practice permission to take and use photographs and digital images of me for the purpose of:

- ❑ **Teaching (i.e. Educational materials)**
- ❑ **Marketing (i.e. Web site, brochures, etc)**

This request and authorization applies to photography or digital images taken on

_____
__

I understand that once my photograph(s) or digital image(s) have been released, Dr. _____ and his/her practice may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

If this authorization has not been canceled, it will expire _____ days after the date signed.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative

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