John L. Starks, DDS
623-7783

Medical Dental Building, Suite 720
509 Olive Way
Seattle, WA 98109

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us–we will be happy to help.

Date _____

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____

Name _____ Birthdate _____ Home Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone ( ) _____

Position _____ Extension _____

Spouse or Parent's Name _____ Employer _____ Work Phone ( ) _____

If Patient is a Student, Name of School / College _____

Whom May We Thank for Referring You?

_____

Person to Contact in Case of Emergency _____ Phone ( ) _____

Financially Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone ( ) _____ Birthdate _____

Employer _____ Work Phone ( ) _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

We expect patient portion not covered by insurance at time of service

Insurance Information (DENTAL ONLY)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone ( ) _____

Position _____ Extension _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

1-800 # _____

Have you been seen in another dental office this year? ☐ Yes ☐ No

Where? _____ Phone ( ) _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone ( ) _____

Position _____ Extension _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

1-800 # _____

John L. Starks, DDS

Consent for Dental Treatment and/or Surgery

I authorize Dr. Starks, staff and any associates to perform dental procedures. I understand that any treatment will be explained to me, as well as alternative surgical and non-surgical treatment plans, and any non-treatment risks.

This is my consent to dental treatment or any surgery or dental work deemed necessary or advisable, as needed in the professional judgment of the doctor, as part of a proposed treatment plan.

I understand that there can be complications as a result of dental treatment, dental surgery, anesthesia or drugs used, in some cases with serious bodily consequences from known and unknown causes. The more common surgical complications are pain, infection, swelling, bleeding, bruising, discoloration, temporary or permanent numbness, and occasionally inflammation of the vein (thrombophlebitis) may occur from an intravenous or an intramuscular injection. Changes in the occlusion or temporomandibular joint may occur. There is a possibility of injury to the adjacent teeth, orthodontic appliances, restorations in other teeth, or other tissues; referred pain to the ear, neck or head; nausea; vomiting; allergic reactions; bone fractures, and delayed healing. Sinus complications, which may include opening into the sinus from the mouth or sinus infection, may occur with removal of upper teeth. Periodontal problems may develop in adjacent teeth which could lead to their loss. Medications and anesthetics may cause drowsiness and lack of coordination which could be increased by the use of alcohol or other drugs. I understand that I should not operate any vehicle or hazardous devices or work while taking such medications until fully recovered from their effects.

I know that the practice of oral and dental surgery is not an exact science and that, therefore, reputable practitioners cannot guarantee results. No guarantee, warranty or assurance has been given by anyone as to the results that may be obtained.

I certify that all information supplied the doctor is complete and accurate with regard to present and past health and medications taken. I further acknowledge that I will not consume food or liquids for six hours prior to surgery, other than that prescribed by the doctor, and have advised him of this fact.

Please do not hesitate to ask Dr. Starks or staff if you have any questions.

Patient's Name: _____

Signature of Patient: _____ **Date**_____

When the Patient is a Minor or Unable to Give Consent, Signature of Person Authorized to Consent for Patient:_____

Relationship to Patient: _____