John L. Starks DDS
509 Olive Way Suite 720
Seattle, WA 98101
(206) 623-7783

Patient Information (Confidential)

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____Relationship:_____

Phone#:

Referral Information

Whom may we thank for referring you to our practice? _____

Responsible Party Information

Person responsible for payment:

Name: _____

Relationship to Patient: _____

Phone (Home): _____ (Work): _____ Ext: _____Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary Insurance Information:

Insurance Plan Name:_____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Information

Insurance Plan Name:_____

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Health Information

Medical Health History

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No if yes, please list:

_____

_____

_____

Do you have or have you had any of the following? (Check all that apply)

☐Heart problems

☐Chest pain

☐Shortness of breath

☐Blood pressure problem

☐Heart murmur

☐Heart valve problem

☐Taking heart medication

☐Rheumatic fever

☐Pacemaker

☐Arthritis

☐Rheumatoid Arthritis

☐Joint Replacement

_____

☐Artificial heart valve

☐Blood problems

☐Easy bruising

☐Frequent nosebleed/Abnormal bleeding

☐Blood disease

☐Anemia

☐Ever require a blood transfusion?

☐Allergy problems

☐Hay fever

☐Sinus problems

☐Skin rashes

☐Taking allergy medication

☐Asthma

☐Intestinal problems

☐Ulcers

☐Weight gain or loss

☐Special diet

☐Constipation/diarrhea

☐Kidney or bladder problems

☐Fainting spells, seizures or epilepsy

☐Stroke(s)

☐Frequent or severe headaches

☐Thyroid problems

☐Persistent cough or swollen glands

☐Cancer/tumor

☐Diabetes

☐Urinate more than six times a day

☐Thirsty or mouth is dry much of the time

☐Family history of diabetes

☐Tuberculosis or other respiratory disease

☐Do you drink alcohol?
If so, how much?

_____

☐Do you smoke/or use smokeless tobacco?
If so, how much?

_____

☐Hepatitis, jaundice or liver trouble

☐Herpes or other STD

☐HIV positive/AIDS

☐Glaucoma

☐Do you wear contact lenses?

☐Head injury

☐Epilepsy or other neurologic disease

☐History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

☐Antibiotics or sulfa drugs

☐Anticoagulants (e.g., Coumadin)

☐High blood pressure medicine

☐Tranquilizers

☐Insulin, Orinase or similar drug

☐Aspirin

☐Digitalis or drugs for heart trouble

☐Nitroglycerin

☐Cortisone (steroids)

☐Natural remedies

☐Bisphosphonates

☐Nonprescription drug/supplements

☐Other

_____

Are you allergic, or have you reacted adversely, to any of the following?

☐**Local anesthetics ("Novocain")**

☐**Penicillin or other antibiotics**

☐**Sulfa drugs**

☐**Barbiturates, sedatives or sleeping pills**

☐**Aspirin, acetaminophen or ibuprofen**

☐**Codeine, Demerol or other narcotics**

☐**Metals**

☐**Latex or rubber dam**

☐**Other**_____

Women

☐ Are you taking contraceptives or other hormones?

☐Are you pregnant?

☐If so, expected delivery date:

_____

☐Are you nursing?

☐Have you reached menopause?
If so, do you have any symptoms?

_____

Dental Health History

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Are you apprehensive about dental treatment? ¨Yes ¨No
Have you had problems with previous dental treatment? ¨Yes ¨No
Do you gag easily? ¨Yes ¨No
Do you wear dentures? ¨Yes ¨No
Does food catch between your teeth? ¨Yes ¨No
Do you have difficulty chewing your food? ¨Yes ¨No
Do you chew on only one side of your mouth? ¨Yes ¨No
Do you avoid brushing any part of your mouth because of pain? ¨Yes ¨No
Do your gums bleed easily? ¨Yes ¨No
Do your gums bleed when you floss? ¨Yes ¨No
Do your gums feel swollen or tender? ¨Yes ¨No
Have you ever noticed slow-healing sores in or around your mouth? ¨Yes ¨No
Are your teeth sensitive? ¨Yes ¨No

Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids? ¨Yes ¨No
Cold foods or liquids? ¨Yes ¨No
Sour foods? ¨Yes ¨No
Sweets? ¨Yes ¨No
Do you take fluoride supplements? ¨Yes ¨No
Are you dissatisfied with the appearance of your teeth? ¨Yes ¨No
Do you prefer to save your teeth? ¨Yes ¨No
Do you want complete dental care? ¨Yes ¨No

How often do you brush? _____x a day
How often do you floss? _____x a day

Does your jaw make noise so that it bothers you? ¨Yes ¨No
or others? ¨Yes ¨No
Do you clench or grind your jaws frequently? ¨Yes ¨No
Do your jaws ever feel tired? ¨Yes ¨No
Does your jaw get stuck so that you can't open freely? ¨Yes ¨No
Does it hurt when you chew or open wide to take a bite? ¨Yes ¨No
Do you have earaches or pain in front of the ears? ¨Yes ¨No
Do you have jaw symptoms or headaches upon awaking in the morning? ¨Yes ¨No
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities? ¨Yes ¨No
Do you find jaw pain or discomfort extremely frustrating or depressing? ¨Yes ¨No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? ¨Yes ¨No
Do you have a temporomandibular (jaw) disorder (TMD)? ¨Yes ¨No
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? ¨Yes ¨No
Are you unable to open your mouth as far as you want? ¨Yes ¨No
Are you aware of an uncomfortable bite? ¨Yes ¨No
Have you had a blow to the jaw (trauma)? ¨Yes ¨No
Are you a habitual gum chewer or pipe smoker? ¨Yes ¨No

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 practioners 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 to 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 his staff if you have any questions.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health I will inform the doctor at the next appointment without fail.

I acknowledge receipt of the **HIPAA Notice of Privacy Practices**.

Any unpaid account balances over 90days are subject to service charges.

Any fee estimates for dental care can only be extended for 6 months from the date of the patient examination.

I have read the above conditions and agree to their content.

_____ Date: _____
Signature of patient

When the patient is a minor or unable to give consent, signature of person authorized to consent for patient:

_____ Date: _____
Signature

Relationship to Patient_____

JOHN L. STARKS, DDS

Suite 720 Medical Dental Building
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Welcome to the dental practice of Dr. John L. Starks, a general family dentist certified and licensed by the State of Washington. Dr. Starks graduated from Northwestern University Dental School in 1979 and completed a residency in hospital dentistry at the University of Washington in 1980. Dr. Starks has practiced family dentistry in the Seattle area since 1980 and is an active member of the American Dental Association, Washington State Dental Association and the Seattle King County Dental Society.

APPOINTMENT POLICY

To respect your time and ours we operate on an appointment basis. Our schedule has emergency time built into each day. Occasional delays may occur due to unexpected emergencies; however, we make a sincere effort to stay on time. We understand that your busy schedule may change; therefore, we confirm your appointment a week in advance. If you do not call back to confirm your appointment or at your request; we will also provide a courtesy call the day before your appointment. Our office cancellation policy is 48 hours (two business days). If you are unable to honor your scheduled appointment, please notify us as soon as possible so that we may offer this time to another patient. It is our policy to charge $65.00 for any missed appointments not cancelled at least 48 hours in advance. _____**(Please initial)**.

EMERGENCIES POLICY

Should an emergency arise, we encourage our patients to call us **immediately** so that we can determine how best to assist you. We have reserved time in our schedule during office hours for emergencies to be seen. After hours, your call will be received by our voicemail system. This will allow you to page Dr. Starks. Please leave a detailed message and Dr. Starks will return your emergency call ASAP.

FINANCIAL POLICY

We expect our patients to pay their estimated portion of fees at the time they receive treatment. If you do not have insurance, please be prepared to fully cover the fees for each visit at the time of service. Our business team will let you know your estimated portion prior to your scheduled appointment. Our office accepts checks, cash, debit cards, MasterCard, VISA, American Express and Discover Card.

Your insurance is a contract between you, your employer and your insurance company. As a courtesy our office will bill your insurance company for your dental treatment. To ensure timely and accurate insurance billing; we ask patients to notify our office of any changes to your coverage on the day of your appointment. Any outstanding balances not paid by insurance are the full responsibility of the patient.

"I have read and understand the financial policy of this practice and agree to its terms. I also understand and agree that such terms may be amended from time-to-time by this practice."

_____ _____

Signature of Patient or Responsible Party if a minor **Date**

_____

Print Name