5 STAR DENTAL
GROUP

frontdesk@5stardentalgroup.com www.5stardentalgroup.com

400 N Loop 1604 E, Suite 315 San Antonio, TX 78232 210-494-3511

Registration Form

Name: Last_____ First_____ MI____ Date of birth_____ Age _____

Soc Sec #_____ Sex: M F Email address_____

Today's date_____ How did you hear about us? _____

Street address_____ Apt #_____ City_____ State_____ Zip_____

Home phone_____ Work phone_____ Cell phone_____

Employer_____ Occupation_____

Emergency contact name_____ Phone #_____

Dental Insurance Information (Primary Carrier)

Insured's Name_____ DOB_____

Insurance Co_____

Address_____ Phone_____

Insured's Employer_____

Insured's SSN_____

Dental Insurance Information (Secondary Carrier)

Insured's Name_____ DOB_____

Insurance Co_____

Address_____ Phone_____

Insured's Employer_____

Insured's Employer_____

Do you have any current health problems? Yes No

Are you under a physician's care now? No Yes, for_____

Physician's name and phone _____

Are you pregnant or nursing? Yes No

Are you allergic to or have you reacted adversely to (circle): Aspirin Local anesthetic Erythromycin Latex Tetracycline Codeine Penicillin Ibuprofen Other_____

What medications are you currently taking? _____

Do you need to pre-medicate with an antibiotic prior to dental treatment? No Yes, name of medication_____

Reason for pre-medication _____

List any other medical information we should know about _____

Do you have high blood pressure? No Yes, current medications _____ Last doctor visit _____

Do you have diabetes? No Yes, current medications_____

Last A1C & date_____ Date of last doctor visit for diabetes care_____

Have you taken, or are you currently taking, any medications for osteoporosis or for your bones? No

Yes, name of medication_____ How long have you been taking this medication? _____

Are you taking any blood thinners? No Yes, name of medication_____

Have you taken any steroid drugs in the last six (6) months? No Yes, name of medication_____ Date_____

Have you had any significant surgeries or hospitalizations? No Yes, please explain_____

Have you experienced any involuntary weight loss recently? No Yes, please explain_____

Please circle any of the following which you have had or presently have:

- ☐ Heart disease/attack
- ☐ Angina Pectoris
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Congenital heart lesions
- ☐ Mitral valve prolapse
- ☐ Artificial heart valve
- ☐ Heart Pacemaker
- ☐ Heart surgery
- ☐ Endocarditis
- ☐ Artificial joints
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney problems
- ☐ Ulcers
- ☐ AIDS/HIV/STD
- ☐ Hepatitis (A, B, C)
- ☐ Liver disease
- ☐ Bleeding problems
- ☐ Epilepsy/Seizures
- ☐ Depression/Anxiety/Emotional
- ☐ Bipolar/Schizophrenia
- ☐ Smoking/Vaping
- ☐ Recreational drugs/alcohol
- ☐ Glaucoma
- ☐ Cancer/chemotherapy/radiation
- ☐ Bruise easily
- ☐ Lung disease/Emphysema/COPD
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Sinus trouble
- ☐ Allergies/hives
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Arthritis/rheumatoid arthritis
- ☐ Cosmetic surgery
- ☐ Osteoporosis/osteopenia
- ☐ Implants
- ☐ Lupus
- ☐ Sjogren's
- ☐ Gastrointestinal problems

Dental History

What brings you to our office? _____

Please answer the following: Are you having any problems now? No Yes, please explain _____

_____

How would you improve your smile? _____

How do feel about your teeth? _____

What would be the ideal thing we could do for you? _____

How long since you have seen a dentist? _____ Reason for that visit? _____

Date of last complete dental exam? _____ Date of last complete set of x-rays_____

Is your present dental health good?	Yes No	Do you have ear congestion?	Yes No
Have you ever been diagnosed with oral cancer?	Yes No	Do you have a family history of oral cancer?	Yes No
Do you have any history of oral facial injury?	Yes No	Do you snore or have sleep apnea?	Yes No
Are you apprehensive about dental treatment	Yes No	Does food tend to get caught between your teeth?	Yes No
Have you ever had periodontal (gum) treatments?	Yes No	Have you had braces in the past?	Yes No
Do your gums bleed, feel tender or irritated?	Yes No	Have you noticed your teeth shifting?	Yes No
Are your teeth sensitive to hot or cold?	Yes No	Has there been any change in your bite?	Yes No
Are your teeth sensitive to pressure?	Yes No	Do you have any loose teeth?	Yes No
Are you unhappy with the appearance of your teeth?	Yes No	Is there any clicking/popping in your jaw joints?	Yes No
How often do you have headaches? Daily Weekly Monthly Never		Are you aware of grinding or clenching your teeth?	Yes No
Do you know the cause?	Yes No	Do you have neck pain or stiffness?	Yes No
The cause is _____		Do you suffer from episodes of vertigo?	Yes No

Have you had any difficulties with past dental treatment? No Yes, please explain_____

Name of previous dentist _____ City _____ State _____

I certify that I have answered all questions regarding my health, medical conditions, and medications to the best of my knowledge. I understand that any changes to my health, medical conditions, and medications need to be provided immediately so that appropriate changes can be made to my treatment.

Patient (or legal guardian) signature_____ Date _____

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YOUR SIGNATURE IS NECESSARY FOR US TO

1. **PROCESS ALL INSURANCE CLAIMS,**
2. **ENSURE PAYMENT FOR SERVICES RENDERED,**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES, AND**
4. **RELEASE INFORMATION TO OTHER MEDICAL/DENTAL PROVIDERS, WHEN NECESSARY, FOR YOUR TREATMENT.**
5. **PLEASE LIST THE FAMILY MEMBERS OR OTHERS AND THEIR PHONE NUMBERS WHOM WE MAY INFORM ABOUT YOUR DENTAL CONDITION AND DIAGNOSIS INCLUDING TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

_____

_____

6. **CAN CONFIDENTIAL MESSAGES SUCH AS APPOINTMENT REMINDERS, TREATMENT QUESTIONS BE LEFT ON YOUR HOME, WORK OR CELLPHONE VOICEMAIL?**
   - o Yes
   - o No

I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all dental, medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Gilberto Tostado. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient_____ Responsible Party _____
(parent, if minor)

Witness_____ Date_____

IF YOUR ACCOUNT REQUIRES COLLECTION ACTIVITY, YOU WILL BE CHARGED COLLECTION FEES IN ADDITION TO YOUR BALANCE.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____,have received and reviewed a copy of *Gilberto Tostado, DDS* health information privacy policies and procedures.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

5 STAR DENTAL
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Our Commitment

At 5 Star Dental Group, we are committed to excellence. We feel that you deserve nothing less when it comes to your health. We use the best materials and techniques available in order to provide you with the quality you have come to expect from us.

We believe that our relationship with you, as with all relationships, needs open and clear communication. We will try to communicate all of your dental needs and estimate your financial information as soon as it becomes evident. We want you to be as informed as possible to help you in your decisions concerning your dental health.

We understand how valuable your time is, so we make every effort to remain on time. We do not double book our appointments. We feel that you deserve our complete and focused attention so that we may provide the best care possible. Your reserved time is exclusively yours.

Your Commitment

We want you to be comfortable with our team. If you ever have any questions about your dental treatment, financial or insurance questions, or any concerns at all, we ask that you notify us as soon as possible. We will be glad to clarify any uncertainties that may arise.

Your portion of your treatment is expected at the time of your services. For your convenience we do accept many forms of payment including, cash, check, Visa, Mastercard, American Express, and we also offer third party financing, which includes both interest free programs and extended financing.

Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48 hour notice is given. If sufficient notice is not given, your account will automatically be charged a $50 missed appointment fee. We ask that you make every effort to keep your reserved time.

Patient/Guardian: _____

Team Member/date:_____