WELCOME TO OUR OFFICE

So that we may provide you with the best care, please fill out these forms completely.

Patient Information

Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Today's Date________________

Last name ________________________ First name_______________________ Middle initial__________

Date of Birth_____/_____/_________ Age__________________ Prefer to be called ________________

Address ____

City____ State___________________ Zip ________________

Occupation ____________________________________ Employer______________________________

If married, please list Spouse's name: ____

Contact Information

Home ____________________Work ____________________ EXT ________ Cell __________________

Email:____

If the patient is a *minor* please fill out the following:

Parents or Guardians name:____

Address ____

City ____State__________________ Zip ______________

Home ____________________Work ____________________ EXT________ Cell__________________

Email:____

Account Information

Person financially responsible for this account is ____

Relationship to patient ____________________ Phone____________________ DL #____________________

Address (*If different from patient*)____

City ____State __________________ Zip_________________

Employer __________________________________ Business phone ____________________ EXT__________

Method of payment: ○ Cash ○ Check ○ Credit Card

Insurance Information

If you have insurance and would like our office to assist you in filing, please provide us with the following information.

Insurance Company ______________________ Insured Employee ______________________

Employee Social Security Number / Date of Birth ______________________ Group Number / Date Employed ______________________

Authorization for Submission of Claims and Assignment of Benefits

I authorize ***Thompson Dental*** to submit claims for payment for services to the health care service plan or insurance company named above on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier.

Authorization of Release of Health Information

I authorize ***Thompson Dental*** to provide any insurance company, health care service plan, self insurers or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.

Printed Patient Name (*if Minor, Parent/Guardian Name)* ______________________ Signature ______________________ Date

Financial Commitment

I understand responsibility for payment for Dental Services provided in this office for myself and my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made with this office.

Patient/Parent/Guardian Signature ______________________ Date ____________

Emergency Contact

Are other members of your family patient's at this office? Yes ○ No ○

If so, please list their names ______________________

So that we may thank them, who referred you to our office? ______________________

Person to contact in case of emergency ______________________

Relationship ______________________ Phone ______________________

Address (*If different from patient*) ______________________

City ______________________ State ____________ Zip ____________

Patient Consent

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient/Parent/Guardian Signature ______________________ Date ____________

Thompson DENTAL

inspiring smiles

Medical History

Patient Name ________________________________ Birth Date ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now? ○ Yes ○ No If yes, please explain________________________

Have you ever been hospitalized or had major surgery? ○ Yes ○ No If yes, please explain ________________________

Have you had a serious head or neck injury? ○ Yes ○ No If yes, please explain ________________________

Are you taking any medications, pills or drugs? ○ Yes ○ No If yes, please explain ________________________

Do you take or have you taken Phen-Fen or Redux? ○ Yes ○ No ________________________

Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use a controlled substance? ○ Yes ○ No

Women are you:

Pregnant / trying to get pregnant? ○ Yes ○ No Taking Oral Contraceptives? ○ Yes ○ No Nursing ○ Yes ○ No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa Drugs

□ Other If yes, please explain ____

Please √ if you have or have had any of the following:

□ AIDS/HIV Positive
□ Alzheimer 's Disease
□ Anaphylaxis
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problems
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/ Fever Blisters
□ Congenital Heart Disorder
□ Convulsions
□ Cortisone Medications
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/ Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pacemaker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Osteoporosis
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice

Have you had any serious illness not listed above? ○ Yes ○ No ____________________

Comments: ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Parent/Guardian Signature ________________________________ Date ____________

Dental History

Patient Name ______________________________ Today's Date ______________

The reason for your visit today is: ______________________________

The date you last visited a dentist: ______________ Last dental cleaning: ______________

How often do you normally have dental check-ups and cleanings? ______________

Your Previous Dentist Information

Name ______________________________ Phone ______________

Address ______________ City ______________ State ______ Zip ______

Please tell us why you are changing dentists: ______________________________

Please √ if you have had or have each of the following:

- ☐ Have bad tastes or mouth odor frequently?
- ☐ Frequently get cold sores, blisters or other oral lesions?
- ☐ Have sore or bleeding gums?
- ☐ Have any loose teeth or changes in your bite?
- ☐ Frequently get food caught between your teeth? Where?
- ☐ Have parents who have experienced gum disease or tooth loss?
- ☐ Clinch or grind teeth while awake or asleep?
- ☐ Bite your lips or cheeks regularly?
- ☐ Hold objects with your teeth (pencils, pens, nails)?
- ☐ Mouth breathe while asleep or awake?
- ☐ Use two pillows when sleeping?

In the last 6 months have you experienced:

- ☐ Clicking or popping of the jaw?
- ☐ Pain (joint, ear, side of face)?
- ☐ Difficulty in opening or closing your mouth?
- ☐ Difficulty chewing on either side of your mouth?
- ☐ Head, neck, shoulder aches?
- ☐ Tired jaws, especially in the morning?

Are any of your teeth sensitive to:

- ☐ Hot or Cold?
- ☐ Sweets?
- ☐ Biting/Chewing?

Have you had any of the following?

- ☐ Oral Surgery?
- ☐ Periodontal Gum Treatment?
- ☐ A serious injury to your head or mouth?
- ☐ Orthodontic treatment (braces / removable appliances)?
- ☐ Your teeth ground down or adjusted?
- ☐ A bite plate or mouth guard?

Please √ Yes or No

Are you nervous about having dental treatment?

☐ Yes ☐ No

Have you ever had an upsetting dental visit?

☐ Yes ☐ No (if so, please describe) ______________

____

☺ Smile Assessment ☺

Are you happy with your smile? ☐ Yes ☐ No, if you could change anything, what would it be? ______________

____

Have you ever considered whitening your teeth? ☐ Yes ☐ No

Are you interested in cosmetic fillings in place of dark fillings? ☐ Yes ☐ No

Have you ever considered straightening your teeth? ☐ Yes ☐ No

Is it important to you to keep all your teeth? ☐ Yes ☐ No

Patient Consent

The information on this form is true to the best of my knowledge. If further information is needed I give this office permission to contact the respective health care providers to release such information. I hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance deemed fit. **I understand it is my responsibility to notify the doctor of any changes in my health or medication on an ongoing basis.**

Patient/Parent/Guardian Signature ______________________________ Date ______________