Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Widowed

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Insurance Information

If you have insurance, we will help you determine the coverage you have available and our office will file your claim electronically for you. Our office reserves the right to decline acceptance of assignment of benefits from your insurance company. All patients are responsible for payment at the time services are rendered. By signing below, I, the subscriber (or my dependents), verify insurance coverage and release all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the release of necessary information to secure payment of benefits. I accept responsibility for all accounts to be paid in full 60 days from the date of service regardless of insurance coverage.

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

Please provide our office with a copy of your card.

X_____
Signature of patient (or parent, if minor)

X_____
Signature of subscriber on insurance policy

Dental History

Reason for today's visit _____

Date of Last dental visit_____ Date of Last x-rays_____ Previous Dentist _____

What would you change about your smile? _____

Medical History

Physician's Name_____ Date of last visit_____ Reason_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/ HIV	Yes	No	Fainting/dizziness	Yes	No	Shortness of Breath	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Sinus Trouble	Yes	No
Arthritis, Rheumatic	Yes	No	Headaches	Yes	No	Skin Rash	Yes	No
Artificial Heart Valves	Yes	No	Heart Problems	Yes	No	Stroke	Yes	No
Artificial Joints	Yes	No	Hepatitis _____	Yes	No	Swollen Neck Glands	Yes	No
Asthma	Yes	No	Herpes	Yes	No	Thyroid Problems	Yes	No
Back Problems	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Bleeding Abnormally	Yes	No	Jaundice	Yes	No	Tumor	Yes	No
Blood Disease	Yes	No	Jaw Pain	Yes	No	Ulcer	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No	Venereal Disease	Yes	No
Chemical Dependency	Yes	No	Liver Disease	Yes	No	Weight Loss- explain	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	FOR WOMEN:		
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No	Are you nursing?	Yes	No
Chemical Dependency	Yes	No	Nervous Problems	Yes	No	Taking BCP?	Yes	No
Cortisone Treatments	Yes	No	Pacemaker	Yes	No	Are you pregnant?		
Cough, persistent/ bloody	Yes	No	Psychiatric Care	Yes	No	Due Date_____	Yes	No
Diabetes	Yes	No	Radiation Treatment	Yes	No			
Drug Use	Yes	No	Respiratory Disease	Yes	No			
Emphysema	Yes	No	Rheumatic Fever	Yes	No	Allergies: _____		
Epilepsy	Yes	No	Scarlet Fever	Yes	No			

Please list any other conditions not listed:_____

Medications: List the Medications you are currently taking, dosage, and reason:

_____

_____

Hospitalizations:

_____

Authorization

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. I also acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service. I acknowledge this it is my responsibility and not an insurance company to pay for all or any services. Any outstanding balance after 30 days may incur a finance charge.

X_____ **Date**_____
Patient, Parent, Or Guardian (must be 18 or older)

Notice of Privacy Practices

This acknowledges the use and disclosure of Personal Health Information. Before signing, please read our Privacy Practice Policies which is available on our website or upon request to gain a clear understanding of how we may use and disclose your Protected Health Information (PHI). I, the undersigned, have read Tina M. Thomas, DMD, PA Privacy Practice Policies and content to the use and disclosure of my PHI for the purpose of healthcare operations, treatment and payment activities. I have been offered a copy of Tina M. Thomas, DMD, PA Privacy practice policies.

X_____ **Date**_____
Patient, Parent, Or Guardian (must be 18 or older)