PATIENT REGISTRATION

Please Complete The Following Confidential Information (both sides)

PATIENT INFORMATION 1a

NAME DATE

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE BIRTHDATE

MALE ☐ ☐ MINOR ☐ SINGLE

FEMALE ☐ ☐ MARRIED ☐ WIDOWED

SOCIAL SECURITY #: _____

FULL TIME COLLEGE STUDENT: Y N NAME OF SCHOOL: _____

EMAIL ADDRESS: _____

METHOD OF PAYMENT

□ Check □ Cash □ Credit Card □ Flex Plan Card

ACCOUNT INFORMATION 2

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME DRIVERS LIC. NO.

RELATIONSHIP TO PATIENT

ADDRESS *(if different from above)*

CITY STATE ZIP

HOME PHONE CELL PHONE

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY STATE ZIP

WORK PHONE CELL PHONE

SPOUSE

NAME DRIVERS LIC. NO.

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY STATE ZIP

WORK PHONE CELL PHONE

DENTAL INSURANCE 3

PRIMARY CARRIER

INSURANCE CO. PHONE:

GROUP NO.

INSURED RELATIONSHIP TO PAT.

BIRTHDATE

UNION OR LOCAL NO.

SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE CO. PHONE:

GROUP NO.

INSURED RELATIONSHIP TO PAT.

BIRTHDATE

UNION OR LOCAL NO.

SOCIAL SECURITY NO.

GETTING TO KNOW YOU 4

REFERRED TO US BY:

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: ***RELATIONSHIP:***

PERSON TO CONTACT IN CASE OF AN EMERGENCY

NAME: ***PHONE NO:***

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME: ***PHONE NO:***

ADDRESS

CITY ***STATE*** ***ZIP***

OFFICE FINANCIAL POLICY

Financial responsibility for services provided belongs to the patient or guardian. Our policy is to receive payment at the time service is provided unless another arrangement is specifically agreed upon in advance.

In the case of patients with dental insurance, our office provides insurance processing as a service, but ultimate responsibility for the account is yours. Any problems with collecting insurance benefits must be worked out between you and your insurer. Our policy is to collect your estimated share of the fee at the time service is provided.

I have read the financial policy statement above and agree to it's terms.

Signature:_____ ***Date:***_____

I authorize my insurance to make payment directly to Dr. William B. Thomas for services provided

Signature:_____

MEDICAL HISTORY *(Please answer all questions yes or no)*

	YES	NO
1. *Do you consider yourself to be in good health at this time?*	☐	☐
2. *Have you been a patient in a hospital during the past two years?*	☐	☐
3. *Have you been under the care of a medical doctor during the past two years?*	☐	☐

Physician's Name: **City:** **Phone No:**

4. *Do you take medications regularly?*	☐	☐

Please List:

5. *Have you **EVER** taken: Etidronate (Didronel)* ☐ Tiludronate (Skelid)☐ Alendronate (Fosamax) ☐
Risedronate (Actonel) ☐ Ibandonate (Boniva) ☐ Pamidronate (Aredia) ☐ Zoledronate (Zometa) ☐

ARE YOU ALLERGIC TO:

PENCILLIN ☐ **ERYTHROMYCIN** ☐ **CODEINE** ☐ **LOCAL ANESTHETICS** ☐
LATEX ☐ **OTHER** ☐ **(Please list):** **NONE** ☐

Please indicate any of the following conditions you have had:

	YES	NO		YES	NO		YES	NO
6. Heart Failure	☐	☐	22. Excessive Bleeding	☐	☐	38. Jaundice	☐	☐
7. Heart Disease	☐	☐	23. Sickle Cell Disease	☐	☐	39. Diabetes	☐	☐
8. Heart Attack	☐	☐	24. Bruise Easily	☐	☐	40. Thyroid Problems	☐	☐
9. Angina	☐	☐	25. Artificial Joints	☐	☐	41. Glaucoma	☐	☐
10. Heart Murmur	☐	☐	26. Arthritis	☐	☐	42. Cancer	☐	☐
11. High Blood Pressure	☐	☐	27. Rheumatism	☐	☐	43. Radiation Therapy	☐	☐
12. Arteriosclerosis	☐	☐	28. Cortisone Therapy	☐	☐	44. Chemotherapy	☐	☐
13. Mitral Valve Prolapse	☐	☐	29. Hives	☐	☐	45. Hepatitis A, B. or C	☐	☐
14. Artificial Heart Valve	☐	☐	30. Hay Fever	☐	☐	46. HIV Positive	☐	☐
15. Pacemaker	☐	☐	31. Sinus Problems	☐	☐	47. Drug/Alcohol Problems	☐	☐
16. Heart Surgery	☐	☐	32. Asthma	☐	☐	48. Ulcers	☐	☐
17. Rheumatic Fever	☐	☐	33. Chronic Cough	☐	☐	49. Nervousness	☐	☐
18. Stroke	☐	☐	34. Emphysema	☐	☐	50. Fainting or Dizzy Spells	☐	☐
19. Blood Transfusion	☐	☐	35. Smoke or Chew Tobacco	☐	☐	51. Seizure Disorders	☐	☐
20. Hemophilia	☐	☐	36. Kidney Problems	☐	☐	52. Psychiatric Treatment	☐	☐
21. Anemia	☐	☐	37. Liver Disease	☐	☐	53. Developmental Disabilities	☐	☐

56. *Have you ever had any disease, condition or problem not listed above?*	☐	☐

Please list: _____

DENTAL HISTORY

Former Dentist **Last full mourth x-rays**

Name: **City:** **Phone No.:** **taken when?**

57. *How often do you have your teeth cleaned?*

☐ Twice a year ☐ Once a year ☐ Infrequently

58. *If you have missing teeth, how have they been replaced?*

☐ Implants ☐ Fixed Bridge ☐ Removable Partial ☐ Full Denture ☐ Not replaced

	YES	NO
59. *Have you ever had any complications from previous dental treatment?*	☐	☐
60. *Do you have jaw/joint problems (clicking, popping, pain, sore jaw muscles, headaches)?*	☐	☐
61. *Are your teeth sensitive to* ☐ sugar, ☐ cold, ☐ heat, ☐ pressure*?*	☐	☐
62. *Do your gums bleed or hurt when brushing?*	☐	☐
63. *Have you ever had periodontal (gum) treatment?*	☐	☐

For Women Only:

Check here if you are pregnant: ☐Yes. What month?_____ Are you nursing? Yes ☐

CONSENT & AUTHORIZATION - I certify that the above information is complete and accurate to the best of my knowledge. I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated for the patient named on this form. I further consent to the doctor's right to employ such assistance as he deems necessary. I understand that prior to treatment, full explanation of the procedures involved will be given by the doctor and/or his staff.

Signature of responsible party: *Date:*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please 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)

_____

_____

_____