PATIENT INFORMATION

FIRST NAME:________________________ LAST NAME:________________________

D.O.B:______________ SSN#: ______________ NICKNAME:______________

HOME PHONE:______________ MOBILE PHONE :______________ SEX: ☐ MALE ☐ FEMALE

ADDRESS:____

CITY:________________________ STATE:________ ZIP:______________

EMAIL ADDRESS: ________________________ OK TO SEND TEXT MESSAGES/EMAILS? ☐ YES ☐ NO

EMERGENCY CONTACT:______________________ PHONE #:__________RELATIONSHIP:__________

HOW DID YOU HEAR ABOUT OUR OFFICE?________________________________

PRIMARY DENTAL INSURANCE

SUBSCRIBER NAME:______________________ D.O.B.:______________ RELATION:______________

EMPLOYER NAME:______________________________ PHONE NUMBER:______________

INSURANCE COMPANY NAME:______________________ PHONE NUMBER:______________

INSURANCE ADDRESS:____

GROUP NUMBER:______________________ MEMBER ID:________________________

SECONDARY DENTAL INSURANCE

SUBSCRIBER NAME:______________________ D.O.B.:______________ RELATION:______________

EMPLOYER NAME:______________________________ PHONE NUMBER:______________

INSURANCE COMPANY NAME:______________________ PHONE NUMBER:______________

INSURANCE ADDRESS:____

GROUP NUMBER:______________________ MEMBER ID:________________________

PATIENT MEDICAL HISTORY

The following information is vital to allow us to provide appropriate care for you. Your information will be kept confidential subject to applicable laws.

PHYSICIAN NAME:______________________________ PHONE NUMBER:__________________

PREFFERED PHARMACY:__________________________ PHONE NUMBER__________________

ARE YOU CURRENTLY UNDER MEDICAL CARE FOR A SERIOUS HEALTH CONDITION? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS? CHECK ALL THAT APPLY.

- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ANXIETY/DEPRESSION
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ CHRONIC SINUS INFECTIONS
- ☐ HEPATITIS
- ☐ DIABETES I -or- II
- ☐ CHRONIC EAR INFECTIONS
- ☐ SEIZURES/EPILEPSY
- ☐ HIV/AIDS
- ☐ HEART MURMUR
- ☐ HEART DISEASE
- ☐ HEMOPHILIA
- ☐ LUNG PROBLEMS
- ☐ LIVER PROBLEMS
- ☐ NEUROLOGICAL PROBLEMS
- ☐ PACEMAKER
- ☐ EPILEPSY
- ☐ DRUG ADDICTION
- ☐ EATING DISORDER
- ☐ HEADACHES/MIGRAINES
- ☐ LOSS OF HEARING
- ☐ GASTRIC ULCERS
- ☐ GI DISEASE
- ☐ KIDNEY DISEASE
- ☐ THYROID DISEASE
- ☐ RHEUMATIC FEVER
- ☐ ORTHOPEDIC PROBLEMS
- ☐ COPD
- ☐ FAINTING/DIZZINESS
- ☐ TUBERCULOSIS
- ☐ ALZHEIMERS DISEASE
- ☐ SLEEP APNEA
- ☐ ACID REFLUX
- ☐ AUTO IMMUNE DISORDER
- ☐ SHINGLES
- ☐ PSYCHIATRIC DISORDER

DO YOU HAVE ANY OTHER DISEASES, HEALTH CONDITIONS, OR SYNDROMES NOT LISTED ABOVE? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY:____

ARE YOU ALERGIC TO ANY MEDICATIONS ? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY:____

HAVE YOU EVER HAD SURGERY OR BEEN HOSPITALIZED? ☐ YES ☐ NO

IF YES, PLEASE SPECIFY:____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND/OR ARE CURRENTLY PRESCRIBED.

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PATIENT DENTAL HISTORY

PLEASE SELECT THE REASON(S) FOR SEEKING DENTAL CARE:

FIRST DENTAL VISIT   ROUTINE CHECK -UP   TOOTHACHE OR SWELLING   CAVITIES

ACCIDENT/INJURY   CROWDING   APPEARANCE OF TEETH   OTHER:______________________

PREVIOUS DENTIST/DENTAL OFFICE:____

DATE OF LAST DENTAL VISIT: ________________________________   DATE OF LAST XRAYS:________________________

HAVE YOU EVER EXPERIENCED ANY COMPLICATIONS OR TRAUMA DUE TO DENTAL CARE? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:____

DO YOUR GUMS BLEED WHEN BRUSHING? ☐ YES ☐ NO

ARE YOU SENSITIVE TO HOT/COLD OR ANYTHING SWEET? ☐ YES ☐ NO

DO YOU GRIND/CLENCH YOUR TEETH? ☐ YES ☐ NO

DO YOU SUFFER FROM JAW PAIN? ☐ YES ☐ NO

IF YES, FOR HOW LONG:____________________________________

DO YOU EXPERIENCE CLICKING OR POPPING OF THE TMJ? ☐ YES ☐ NO

DO YOU WEAR A NIGHT GUARD OR SPORTS GUARD? ☐ YES ☐ NO

DO YOU WEAR DENTURES? ☐ YES ☐ NO

FULL OR PARTIAL DENTURES?________________________________

HAVE YOU BEEN DIAGNOSED WITH PERIODONTAL DISEASE? ☐ YES ☐ NO

PATIENT SIGNATURE:____   DATE:________________________

PATIENT AGREEMENT

Please read each item and initial next to each.

_________ As a courtesy to our patients using insurance; we are happy to file claims. All benefits quoted are estimates only and are not a guarantee of payment. If you have questions regarding your coverage benefits, please contact your insurance company directly.

________ If insurance coverage is terminated or has not been updated with Thompson Smiles; the patient will be responsible for all incurred charges.

_________ Thompson Smiles provides the most up to date services. These services include, but are not limited to, composite (tooth-colored fillings), crowns and cosmetic dentistry. Insurance companies may not cover all procedures. In these cases, the patient will be responsible for any unpaid balances.

_________ All estimated fees are due at the time of treatment. We are happy to discuss finance options. All financial arrangements must be made **before** any treatment is rendered.

________ One American dies every hour due to oral cancer. For this reason, we conduct an oral cancer screening once per year. If your dental insurance does not cover this procedure, you will be responsible for the fee. $ **FEE**

_________ Treatment plans and associated fees may change without notice if it is in the best interest of the patient at the time of treatment.

CANCELLATION POLICY

Here at Thompson Smiles we make every effort to maintain an efficient and effective schedule. We pride ourselves with being on time and prepared for your scheduled appointment. We understand that emergencies and unforeseen circumstances may arise, causing schedule changes. We always try our best to ensure these circumstances do not inconvenience other patients and we appreciate your understanding of those situations.

As a courtesy, our office will make a confirmation call 48 hours prior to your scheduled appointment. If you cannot make your appointment as scheduled, please notify our office no less than 24 hours in advance. There will be a $75 fee for a cancellation or no-show appointment without proper notification. This fee is not covered by insurance and is the responsibility of the patient.

PATIENT SIGNATURE:____ DATE:________________

NOTICE OF PRIVACY PRACTICES AND HIPAA ACKNOWLEDGMENT

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information regarding your care.

I understand that, by signing this consent form, I am giving you my consent to your use and disclosure of protected health information to carry out treatment, payment activities and health care operations.

PATIENT NAME::____ D.O.B:___________________________

PATIENT SIGNATURE:____ TODAYS DATE:____________________