

Dental History

Please check any of the following problems that apply to you.

- Sensitivity (hot cold sweets)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or filling breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in mouth

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Periodontal (gum) treatments

Please share the following dates with us:

- Your last cleaning ____/____
- Your last oral cancer screening ____/____
- Your last complete X-Rays ____/____

Are you interested in whitening your teeth? _____

Do you smoke or use chewing tobacco? _____

How much? _____ **How long?** _____

If you could change your smile, you would:

- Make them brighter
- Make them straighter
- Close spaces
- Replace black metal fillings with natural, tooth-colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

We appreciate the time you've taken to help us with your dental care.

Medical History

Patient Name _____

Date _____

Do you have a personal physician? Yes No

Physician's Name: _____

Phone # _____ Date of Last Visit _____

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list each one _____

Are you allergic to any of the following drugs?

Y N Penicillin Y N Tetracycline Y N Latex

Y N Asprin Y N Dental Anesthetics Y N Sulfa

Y N Erythromycin Y N Codeine Y N Other

List any other drugs that you are allergic to: _____

Have you ever had any of the following diseases or medical problems ?

Y N Heart Attack Y N Tuberculosis (TB)

Y N Stroke Y N Epilepsy

Y N Cancer/Chemotherapy Y N Seizures

Y N Heart Murmur Y N Fainting Spells

Y N Rheumatic Fever Y N Previous Drug/Alcohol Abuse

Y N Heart Problems Y N Venereal Disease

Y N HIV +/-Aids Y N Hemophilia/Abnormal Bleeding

Y N Heart Surgery Y N Pacemaker

Y N Mitral Valve Prolapse Y N Ulcers

Y N Kidney/Liver Problems Y N Colitis

Y N Artificial Bones/Joints Y N Congenital Heart Defect

Y N Artificial Valves Y N Radiation Treatment

Y N Sinus Problems Y N Asthma

Y N High Blood Pressure Y N Arthritis

Y N Low Blood Pressure Y N Hospitalized for any reason

Y N Blood Transfusion Y N Respiratory Problems

Y N Fever Blisters Y N Hepatitis A

Y N Psychiatric Problems Y N Hepatitis B

Y N Diabetes Y N Glaucoma

Please discuss any serious medical condition (s) that you have ever had:

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes No If yes # of weeks _____

Are you nursing? Yes No

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Thomas and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness, I understand that occasionally needles break and may require surgical retrieval.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for may benefit for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

Signature (Parent, legal guardian or authorized agent of patient)

Date

Payment Agreement

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

In Accordance with the Federal Truth-In-Lending Act, please be advised of our financial policy and extension of credit.

1. Payment is required at the time service is rendered unless previous arrangements have been made.
2. A finance charge of 1.5% per month will be added to your bill if payment has not been received within 45 days. Interest not paid when due shall be added to and become part of the principal.
3. A service charge of \$15.00 will be assessed on all returned checks
4. There will be a \$10.00 late charge assessed on any amount delinquent over 10 days past the agreed payment date.
5. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs.
6. A credit report may be pulled if financial arrangements are being made by our office.

INSURANCE AGREEMENT

1. We are happy to serve you by submitting your insurance claims directly to your insurance company without charge. We make every effort to submit your claims the day after the service is performed.
2. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
3. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.
4. For your convenience we will **ESTIMATE** the portion of your total fee that your insurance company will cover. This is **JUST AN ESTIMATE**. After insurance benefits, you are responsible for **ANY UNPAID BALANCE**. We will ask you to bring with you at the time of service the **ESTIMATED** uncovered portion of the total fee.

I authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize the release of information for insurance and collection purposes. Further, I agree that any fees accrued at Dr. Thomas' office will not be included in any bankruptcy proceedings. I grant my permission to you or your assignee to telephone me at home or at my work place to discuss matters related to this form.

Signature of responsible party

Date

HIPPA: NOTICE OF PRIVACY PRACTICES

Dr. Allan S. Thomas will protect your privacy under all circumstances. Protected health information will only be released as requested by you for a transfer of your records, or with permission upon recommendation from Dr. Allan S. Thomas, for a procedure by another practitioner on your behalf.

I, _____, understand the explanation of this office's Notice of Privacy Practices.

Signature of Patient or Guardian

Date