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PATIENT INFORMATION CARD

Date_____

Last Name: _____ First Name: _____ Initial: _____ Birthdate _____

Address: _____
Street City State Zip

Home Phone_____ Cell Phone_____ Driver's License #:_____

Place of Employment: _____ Business Phone: _____

If minor, school attending: _____ Social Security #: _____

Spouse or Guardian: _____ Employed By: _____

Business Phone: _____ Has anyone in your immediate family been seen here? _____

E-mail Address:_____ Referred By: _____

HEALTH HISTORY

Physician: _____

Last physical exam _____

1. **Are you taking any medications or substances** .... ❑ Y ❑ N
   List:_____
2. **Are you allergic to any medications or substances?** . ❑ Y ❑ N
   (❑ Penicillin, ❑ antibiotics, ❑ anesthetics, ❑ codeine ❑ sulfa, ❑ other)
3. **Women:** Are you pregnant? ..... ❑ Y ❑ N
   Are you taking birth control medication? ..... ❑ Y ❑ N
4. **Do you have or have you had any of the following?**
   Please Check Each Box:

Y N	Y N	Y N
❑ ❑ premedicate	❑ ❑ diabetes	❑ ❑ bleeding problems
❑ ❑ heart disease	❑ ❑ asthma	❑ ❑ anemia
❑ ❑ heart murmur	❑ ❑ radiation/chemotherapy	❑ ❑ latex allergies
❑ ❑ pacemaker	❑ ❑ serious illness	❑ ❑ epilepsy or seizures
❑ ❑ rheumatic fever	❑ ❑ artificial joints	❑ ❑ HIV positive
❑ ❑ heart valve problems	☐ ☐ rheumatism	☐ ☐ AIDS
❑ ❑ osteoporsis	☐ ☐ hepatitis	☐ ☐ high blood pressure
❑ ❑ mitral valve prolapse	☐ ☐ TB	☐ ☐ low blood pressure
❑ ❑ kidney problems	☐ ☐ psychiatric treatment	☐ ☐ oral piercings
❑ ❑ liver problems		

   Any diseases or conditions not listed? _____
5. **History of Habits:**
   Tobacco:
   ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Snuff ❑ Chew
   Beverages:
   ❑ Coffee ❑ Sweet Tea ❑ Soft Drinks ❑ Diet Drinks

INSURANCE INFORMATION

Do you have dental insurance?_____

Name of insurance company:_____

_____

Subscriber Name:_____

Subscriber Birthdate:_____

Subscriber Social Security #_____

Employer:_____

FEES & INSURANCE

The best dental services are based on a friendly, mutual understanding between doctor and patient. Therefore, we would like to acquaint you with our office payment policy We request that payment be made in full the day treatment is rendered. We do accept Master Card, Visa, American Express and Discover. A dental charge card, Care Credit, is available with approved credit. If you have any questions, please ask the financial coordinator. There will be a $60.00 service charge on all returned checks. For any reason your account goes to an outside agency for collection, your signature serves as your authorization to disclose patient information necessary for collection activities. If incurred, patient (or responsible party) agrees to pay for all cost of collections (33 1/3 of balance), including court costs and any attorney fees.

Since we perform dental services for you, you are financially responsible to us. Your insurance company has an obligation to you-none to the doctor. We will help you with your insurance in every way possible. We will supply any information the insurance company requests to help you receive payment. Please feel free to check with the financial coordinator concerning any questions you might have regarding our office policy on insurance.

I have read and understand the above stated policies.

_____
Patient Signature Date

DENTAL HISTORY

Frequency of Care: 3 mos. 6 mos. 1-2 yrs. 2-5 yrs. 5 or more years

Last teeth cleaning appointment: _____ Periodontal /Gum Treatment: _____

Date and reason for last dental visit: _____ Were dental x-rays taken? ❑ Y ❑ N

Evaluation of past dental experience: _____

Reason for this dental visit: _____

1. **Have you lost any teeth or have any teeth been removed?** .. ❑ Y ❑ N
   Why? _____
2. **Have they been replaced** ..... ❑ Y ❑ N
3. **How have they been replaced?**
   Fixed bridge /Implants _____ Age _____
   Removable bridge _____ Age _____
   Denture _____ Age _____
4. **Are you happy with the replacement?** ..... ❑ Y ❑ N
5. **Have you ever had any problems or complications with previous dental treatment?** ..... ❑ Y ❑ N
6. **Do you clench or grind your teeth?** ..... ❑ Y ❑ N
7. **Does your jaw click or pop?** ..... ❑ Y ❑ N
8. **Have you experienced any pain or soreness in the muscles of your face or around your ear?** ..... ❑ Y ❑ N
9. **Do you have frequent headaches, neckaches, or shoulder aches?** ❑ Y ❑ N
10. **Have you ever been told you have TMJ?** ..... ❑ Y ❑ N
11. **Are any of your teeth sensitive to:** ❑ Hot ❑ Cold ❑ Sweets ❑ Pressure
12. **Are any of your teeth loose, chipped or broken?** ..... ❑ Y ❑ N
13. **What would you change about the appearance of your teeth?**

    _____

    On a scale of 1-10, please rate your teeth on appearance and whiteness, 10 being perfect.
    ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

    _____
14. **Do your gums bleed or hurt?** ..... ❑ Y ❑ N
15. **Do you feel your breath is offensive at times?** ..... ❑ Y ❑ N
16. **Have you ever had gum treatment or surgery?** ..... ❑ Y ❑ N
17. **Have you had any orthodontic treatment?** ..... ❑ Y ❑ N
18. **Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike** ..... ❑ Y ❑ N

OFFICE USE

_____

AUTHORIZATION FOR RELEASE OF PHOTOGRAPHS

I hereby consent that the photographs and x-rays that are taken of me may be used by Dr. Dan Thompson or his agents. I understand that I will not be compensated for the use of my photographs.

_____
Patient Signature Date

We Welcome New Patients and Referrals.

Doctor Signature _____