Michael R. Thomas D.D.S., P.L.L.C

PATIENT REGISTRATION

ABOUT YOU

First Name:_____ **Last Name:**_____ **Middle Initial:**_____

○ Male ○ Female Date of Birth: _____/_____/_____ Social Security#: _____–_____–_____

Address:_____ City/State: _____ Zip: _____

Home Phone:_____ Cell Phone:_____ Email:_____

Name of Spouse: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Are you a full time student?: ☐ Y ☐ N If Yes, where: _____

Employer: _____ Employer Address: _____ Employer Phone: _____

Who may we thank for Referring you: _____ ☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Employer ☐ Other_____

Who is your Preferred Dentist: _____ Preferred Hygienist: _____ Pharmacy: _____

EMERGENCY INFORMATION

Person to contact in case of emergency: _____ Phone: _____ Relationship: _____

PERMISSION TO SHARE INFORMATION (FOR PATIENTS 18 years of age and older)

☐ I give my permission for Michael R. Thomas D.D.S., P.L.L.C. to share my medical/dental and account information with the following persons _____
Initial

Name:_____ Relationship to Patient: _____

Name:_____ Relationship to Patient: _____

ACCOUNT INFORMATION

Who is responsible for this account ☐ Self ☐ Parent ☐ Spouse ☐ other ☐ **I DO NOT HAVE DENTAL INSURANCE**

Person responsible for this account if not self: _____ Address:_____ Phone: _____

Date of Birth: _____/_____/_____ City/State: _____ Zip: _____

PRIMARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____–_____–_____

Policy Holder Address:_____ City/State: _____ Zip: _____

Policy Holder Home Phone:_____ Cell Phone:_____

Policy Holder Employer:_____ Address:_____Phone: _____

Insurance Company Name: _____ Address:_____

City/State :_____ Zip: _____

Group Number: _____ Policy Holder ID#: _____

SECONDARY INSURANCE

Name of Policy Holder:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Policy Holder Date of Birth:_____/_____/_____ Policy Holder SSN: _____–_____–_____

Policy Holder Address:_____ City/State: _____ Zip: _____

Policy Holder Home Phone:_____ Cell Phone:_____

Policy Holder Employer:_____ Address:_____ Phone: _____

Insurance Company Name: _____ Address:_____

City/State :_____ Zip: _____

Group Number: _____ Policy Holder ID#: _____

PATIENTS UNDER 18 years of age (MINORS) Name of person completing the patient registration: _____

Relationship to patient: ○ Parent ○ Grandparent ○ Other_____

Name of person accompanying you to todays appointment _____

Relationship to patient: ○ Parent ○ Grandparent ○ Other_____

MY MEDICAL HISTORY

Name of personal physician: _____ Address:_____ Phone: _____

My current health condition is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any serious health problems or surgeries in the last 5 years ☐ Yes ☐ No If YES, please explain: _____

_____

FOR WOMEN ONLY: Are you pregnant ☐ Yes ☐ No If yes, how many months _____

ALLERGIES Please check if you are allergic to any of the following

☐ Local Anesthetics ☐ Pennicillin or Other Antibiotics ☐ Sulfa Drugs ☐ Aspirin ☐ Barbituates, sedatives, Sleeping pills

☐ Codeine/Other narcotics ☐ Shellfish or iodine ☐ Latex sensitivity ☐ Other_____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain:_____

Please list Prescription medications you take:_____

*Have you ever been told you need a pre-med antibiotic for dental visits ☐ Yes ☐ No If yes, why: _____

MY DENTAL HISTORY On a scale of 1 to 5 (1= low/poor, 5 = high/good) please circle:

○ ○ ○ ○ ○ How do you feel your overall dental health is?
○ ○ ○ ○ ○ Over the last 10 years rate how faithfully you have had your teeth cleaned?
○ ○ ○ ○ ○ What is your level of sensitivity to dental procedures?
○ ○ ○ ○ ○ How do you feel about your smile and the look of your teeth?
1 2 3 4 5

Date of your last hygiene cleaning: _____ Are you interested in having regular hygiene cleanings? ☐ Yes ☐ No

What is the main reason for your visit today?

☐ Tooth Pain ☐ I need a check up ☐ Cleaning ☐ Invisalign (Clear Braces)
☐ Whitening ☐ Cosmetic Dentistry ☐ Dentures ☐ Implants ☐ Other

The information I have given is true and accurate to the best of my knowledge.

Signed by_____Date_____

I agree to be responsible for all charges for dental services and materials not paid by my dental insurance, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits otherwise payable to me, to be paid directly to Michael R. Thomas D.D.S., P.L.L.C.

_____ **INITIALS**

Appointment Cancellation Policy
When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of 24 hours. We understand conflicts arise ; however failing your appointment or canceling without adequate notice more than once may result in a charge to your account or discontinuation of services.

_____ **INITIALS**

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