

# 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?**

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

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