Thomas Dental Care

Patient Information

Name _____
Address _____
City, State, Zip_____
Home phone _____
Work phone _____
Cell phone _____

May we text you regarding appointments? Yes ☐ No ☐

Email address _____
Social Security # _____
Drivers License # _____
Date of birth _____
Marital status_____ Gender _____
Person to contact in case of emergency:_____ph#_____

Person responsible for account:_____
Relationship to patient_____
Phone number_____

Previous dentist _____
Phone number _____
Last visit _____

Physician's name _____
Last visit _____ Phone _____

Employer _____
Position _____

Information about your spouse or parent

Name _____
Business/Home phone _____

The above information is accurate to the best of my knowledge:

Signature _____
Today's date _____

Whom may we thank for referring you? _____

I acknowledge I have received a copy of this office's Notice of Privacy Practices.

_____
Patient Signature Date

I acknowledge I have read a copy of the Dental Materials Fact Sheet dated June 2004 and was given one if I requested.

_____
Patient Signature Date

If applicable fill out completely

Insurance company information.

Primary Insurance

Name of insured _____
Date of birth _____
Social Security #. _____
Insurance carrier _____
Employer _____
Group plan #_____

Secondary Insurance

Name of insured_____
Date of birth_____
Social Security #_____
Insurance carrier_____
Employer_____
Group plan #_____

I AUTHORIZE THIS OFFICE TO COLLECT DIRECTLY FROM MY INSURANCE COMPANY, THE AMOUNT OF MONEY OWED BY THEM FOR DENTAL SERVICES.

Signature_____