THOMSEN
dental group PC

1116 South 105th Street • Omaha, Nebraska 68124 • (402) 393-1992 • www.thomsendental.com

Patient Name: Last | First | MI | Preferred Name

Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child

Birth Date: SS #. Today's Date:

Email Address: Last Dental Visit:

Phone: Home | Work | Ext | Mobile | Fax

Address:

City | State | Zip Code

Employer Name: Phone:

Address:

City | State | Zip Code

Spouse's Information

Name: Last | First | MI | Preferred Name

Birth Date: SS #. Email Address:

Phone: Home | Work | Ext | Mobile

Address:

City | State | Zip Code

Employer Name: Phone:

Address:

City | State | Zip Code

Whom may we thank for referring you to our practice?

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Have you had any of the following? Please circle those that apply.

Allergies to medications:
- Penicillin
- Aspirin
- Codeine
- Latex
- Other_____

Anemia
Blood Disease
Excessive Bleeding
Arthritis
Fibromyalgia
Artificial Joints
Dizziness
Fainting
Head Injuries
Mental Disorders
Nervous Disorders
Stomach Problems
Ulcers

Sinus Problems
Asthma
Hay Fever
Allergies
Shortness of breath
Respiratory Problems
Heart Disease
Heart Attack
Pace Maker
Heart Valve Replacement
Stroke
High Blood Pressure
Cancer
Radiation Treatment Tumors
Diabetes
Kidney Disease
Liver Disease
Hepatitis
Glaucoma

Rheumatic Fever
Epilepsy
Birth Control Pills
Pregnancy
- Due Date_____

Smoking
- How much_____

Blood Donor Ineligible
Snoring
Sleep Apnea

Medications:

Any other medical conditions that require explanation.

Name of Physician and Phone Number:

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These are things important to me about my dental health:

Please Check One

My mouth is

- ◯ very comfortable.
- ◯ moderately comfortable.
- ◯ uncomfortable.

I [I am]

- ◯ think the appearance of my mouth is excellent.
- ◯ satisfied with the appearance of my mouth.
- ◯ dissatisfied with the appearance of my mouth.

I

- ◯ will do anything to keep my natural teeth.
- ◯ want to keep my teeth, but have a certain budget of time and money I am willing to spend on them.
- ◯ don't care whether I keep my teeth or not.

I

- ◯ have set goals for my oral health with a previous dentist.
- ◯ want to set goals concerning my dental health.
- ◯ never set goals concerning my dental health.

I

- ◯ have always done the best that was recommended for my dental health.
- ◯ have not done what dentists have recommended for my mouth.
- ◯ rarely go, and don't care much about having my dental work completed.

I have

- ◯ put dentistry for myself and my family high on my priority list.
- ◯ put dentistry for myself and my family low on my priority list.
- ◯ it's on my list but hard to find.

I think my present state of dental health is

- ◯ excellent.
- ◯ good.
- ◯ poor.

I aspire to a mouth with

- ◯ excellent health.
- ◯ good health.
- ◯ poor health.

What are your primary concerns?

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Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian [responsible party]:

Signature: _____ Date: _____

Printed Name: _____