



WELCOME TO OUR OFFICE

So that we may provide you with the best care, please fill out these forms completely.

Patient Information

Mr. Mrs. Ms. Dr. Today's Date _____

Last name _____ First name _____ Middle initial _____

Date of Birth _____ Age _____ Prefer to be called _____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

If married, please list Spouse's name: _____

Contact Information

Home _____ Work _____ EXT _____ Cell _____

Email: _____

If the patient is a *minor* please fill out the following:

Parents or Guardians name: _____

Address _____

City _____ State _____ Zip _____

Home _____ Work _____ EXT _____ Cell _____

Email: _____

Emergency Contact

Are other members of your family patients at this office? Yes No

If so, please list their names _____

So that we may thank them, who referred you to our office? _____

Person to contact in case of emergency _____

Relationship _____ Phone _____

Address (If different from patient) _____

City _____ State _____ Zip _____

Account Information

Person financially responsible for this account is _____

Relationship to patient _____ Phone _____ DL # _____

Address (If different from patient) _____

City _____ State _____ Zip _____

Insurance Information

If you have insurance and would like our office to assist you in filing, please provide us with the following information.

Primary Insurance Company

Secondary Insurance Company

Primary Policyholder Name

Secondary Policyholder Name

Employee Social Security Number / Date of Birth

Employee Social Security Number / Date of Birth

Employer Name / Group #

Employer Name / Group #

Authorization for Submission of Claims and Assignment of Benefits

I authorize **Thompson Dental** to submit claims for payment for services to the health care service plan or insurance company named above on my behalf and in my name, and assign such provider the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any balances not satisfied by my insurance benefits, regardless of the basis for nonpayment by my insurance carrier.

Authorization of Release of Health Information

I authorize **Thompson Dental** to provide any insurance company, health care service plan, self insurers or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits.

Printed Patient Name (if Minor, Parent/Guardian Name)

Signature

Date

Patient Consent

I understand that the information given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient/Parent/Guardian Signature _____ Date _____

Medical History

Patient Name _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physicians care now? Yes No If yes, please explain _____
- Have you ever been hospitalized or had major surgery? Yes No If yes, please explain _____
- Have you had a serious head or neck injury? Yes No If yes, please explain _____
- Are you taking any medications, pills or drugs? Yes No If yes, please explain _____
- Do you take or have you taken Phen-Fen or Redux? Yes No _____
- Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use a controlled substance? Yes No

Women are you:

Pregnant / trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs
- Other If yes, please explain _____

Please ✓ if you have or have had any of the following:

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

Have you had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Parent/Guardian Signature _____ Date _____

Dental History

Patient Name _____ Today's Date _____

The reason for your visit today is: _____

The date you last visited a dentist: _____ Last dental cleaning: _____

How often do you normally have dental check-ups and cleanings? _____

Your Previous Dentist Information

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Please tell us why you are changing dentists: _____

Please v if you have had or have each of the following:

- Have bad tastes or mouth odor frequently?
- Frequently get cold sores, blisters or other oral lesions?
- Have sore or bleeding gums?
- Have any loose teeth or changes in your bite?
- Frequently get food caught between your teeth? Where?
- Have parents who have experienced gum disease or tooth loss?
- Clench or grind teeth while awake or asleep?
- Bite your lips or cheeks regularly?
- Hold objects with your teeth (pencils, pens, nails)?
- Mouth breathe while asleep or awake?
- Use two pillows when sleeping?

Are any of your teeth sensitive to:

- Hot or Cold?
- Sweets?
- Biting/Chewing?

Have you had any of the following?

- Oral Surgery?
- Periodontal Gum Treatment?
- A serious injury to your head or mouth?
- Orthodontic treatment (braces / removable appliances)?
- Your teeth ground down or adjusted?
- A bite plate or mouth guard?

In the last 6 months have you experienced:

- Clicking or popping of the jaw?
- Pain (joint, ear, side of face)?
- Difficulty in opening or closing your mouth?
- Difficulty chewing on either side of your mouth?
- Head, neck, shoulder aches?
- Tired jaws, especially in the morning?

Please v Yes or No

Are you nervous about having dental treatment?

- Yes No

Have you ever had an upsetting dental visit?

- Yes No (if so, please describe) _____

Is this visit related to an accident? Yes No

(if so, please describe) _____

😊 Smile Assessment 😊

Are you happy with your smile? Yes No, if you could change anything, what would it be? _____

Have you ever considered whitening your teeth? Yes No

Are you interested in cosmetic fillings in place of dark fillings? Yes No

Have you ever considered straightening your teeth? Yes No

Is it important to you to keep all your teeth? Yes No

Patient Consent

The information on this form is true to the best of my knowledge. If further information is needed I give this office permission to contact the respective health care providers to release such information. I hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance deemed fit. **I understand it is my responsibility to notify the doctor of any changes in my health or medication on an ongoing basis.**

Patient/Parent/Guardian Signature _____ Date _____



1550 S Custer RD Ste 100, McKinney, TX 75070 * 972-346-2992 office

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

****You may refuse to sign this Acknowledgement****

I, _____, have received a copy of Dr. Ryan Thompson's Notice of Privacy Practices.

_____ {Signature} _____ {Date}

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
(Please Specify) _____

Names of other individuals that I hereby authorize Dr Thompson's practice to disclose private information to on my behalf ie: account information, treatment, appointments, etc.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

AUTHORIZATION FOR SIGNATURE ON FILE

I, _____, hereby authorize Thompson Dental to affix my name to any and all claims or documents as related to any and all health benefits due to me or my dependents. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, 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 any information related to this claim.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Thompson Dental. This "Signature on File" will be valid from this date forward. A photocopy of this document may act as the original.

_____ {Printed Name} _____ {Relationship to policy holder}

_____ {Signature} _____ {Date}