PATIENT REGISTRATION

Patient's name _____ Birth date _____

Name of spouse/partner _____ Birth date _____

If a child, parent's name _____

Street address _____ Phone _____

City _____ State _____ Zip _____

Patient employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Spouse/partner employed by _____ Phone _____

Business address _____

Present position _____ How long held _____

Purpose of this appointment _____

In case of emergency, who should be notified _____ Phone _____

Person responsible for this account _____

Social Security number _____

_____

Spouse/partner's Social Security number _____

_____

_____ _____ _____

_____ _____

If you have insurance, name of insured _____

Name of insurance company _____ Policy no. _____

If spouse/partner has insurance, name of insured _____

Name of insurance company _____ Policy no. _____

Whom may we thank for referring you _____

Your Signature _____ **Date** _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Single ☐
Widowed ☐
Married ☐
Long Term Partner ☐
Divorced ☐
Separated ☐

NAME_____ DATE_____

HEALTH HISTORY

1. Have you seen a physician within the past 2 years?_____
   If yes, for what problem?_____
2. Please give the name and address of your regular physician:
   _____
3. Have you been a patient in the hospital within the past 2 years?_____
   If yes, for what problem?_____
4. Circle any of the following which you have had or presently have:

Heart failure	Chronic cough	Hepatitis
Heart disease or attack	TB	Liver disease
Angina pectoris	Asthma	Yellow jaundice
High blood pressure	Hay fever	Blood Transfusion
Heart murmur	Sinus trouble	Drug addiction
Congenital heart lesions	Diabetes	Hemophilia
Artificial heart valve	Thyroid disease	Venereal disease
Heart pacemaker	Genital herpes	Heart surgery
Chemotherapy	Cold sores/Fever blisters	Anemia
Arthritis	Epilepsy	Stroke
Cortisone medicine	Fainting or dizziness	Kidney trouble
Glaucoma	Nervousness	Ulcers
AIDS	Psychiatric treatment	Emphysema
Sickle cell disease	Enlarged lymph nodes	

5. Have you ever had any operations or surgery?_____
   If yes, what was the problem?_____
6. Have you ever had excessive bleeding requiring special treatment?_____
7. Are you taking any medicine, drugs or pills of any kind?_____
   If yes, what kind?_____
8. Do you have any allergies to drugs or medicines?_____
   If yes, to what and how do you react?_____
9. Have you ever had an unusual reaction to a dental anesthetic?_____
10. Have you unintentionally lost or gained more than 10 pounds in the past year?___
11. Are you on a special diet?_____
12. Has you medical doctor ever said you have a cancer or tumor?_____
13. Do you have any disease, condition or problem not listed?_____
14. WOMEN: Are you pregnant now?_____
    Are you practicing birth control?_____
    Do you anticipate becoming pregnant?_____

DATE:_____ SIGNATURE:_____

Clifford Thomas D.D.S., M.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

FINANCIAL STATEMENT

We are committed to providing you with the best possible dental care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment, give you as detailed an estimate as possible in writing, and answer any questions that we can about your insurance. If you have dental insurance, we will assist you in receiving your maximum allowable benefits.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between you, your employer and an insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your dental care providers, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. We will help you by processing your insurance claim form and sending it in promptly. All co-pays will be collected at time of service. Payment can be made by cash, check or Visa/MasterCard/Discover/American Express.

For your convenience we offer a third party financing plan, Care Credit, for treatment plans over $300, with approved credit. Depending on the cost of your treatment plan, 3, 6, and 12 month interest free plans are available.

I authorize the release of dental information necessary to process an insurance claim. I authorize payment of dental benefits to the provider for professional services rendered. I understand that when my dental insurance coverage excludes or does not fully cover services rendered, I am responsible for the account balance in full.

Responsible Party Signature:_____ Date:_____

CANCELLATION STATEMENT

We understand that things come up that are out of your control. However, when an appointment is failed or is cancelled with less than 24 hours notice it is extremely difficult for us to fill that appointment time. If this occurs you will be charged for the overhead cost of your missed appointment.

Responsible Party Signature:_____ Date:_____