PATIENT REGISTRATION

ID: Chart ID:

First Name:______________________Last Name: _____________________Middle Initial:__

Preferred Name: ____

Address: ______________________________ Address 2: ____________________________

City, State, Zip: ____

Home Phone: ________________ Work Phone: ______________Cell Phone: ___________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:___________ Social Security #: ____________________

E-mail: _______________________________ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist:_______________________ Preferred Hygienist: __________________

Preferred Pharmacy:____________________ Referred By: _________________________

Primary Insurance Information:

Name of Insured: ____________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ______________________ Carrier ID: ________________________________

Insured Social Security #: __________________________ Insured Birth date: ______________

Employer: __________________________ Insurance Company: ___________

Secondary Insurance Information:

Name of Insured: ____________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _______________________ Carrier ID: _____________________________

Insured Social Security #: _________________ Insured Birth date:_____________________

Employer: ________________________________ Insurance Company: __________________

Patient (Guardian) Signature: ______________________________ Date: ______________

Time 9:58 AM

Thompson Family Dentistry

Date 4/18/2016

*Thompson Family Dental Medical History Form

Patient Name: Birth Date: Date Created:

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.

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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.

Signature of Patient, Parent or Guardian:

X Date:___________

Thompson Family Dentistry
130 Crossroads Plaza
Mt. Pleasant, PA 15666

Authorization to Leave Medical Information on Voicemail

Patient Name: ______________________________

Patient Date of Birth: ________________________

Preferred Phone Number to Leave Information on: __________________

Thompson Family Dentistry providers and their Staff recognize confidentiality as a very important part of your relationship with them. By signing this, you are agreeing to allow us to leave voicemail messages regarding treatment and treatment plans (including the amount the patient would owe on a procedure) on your voicemail.

☐ I authorize Thompson Family Dentistry to leave voicemail messages regarding my treatment or treatment plans at the phone number listed above.

☐ I **DO NOT** want messages regarding my treatment or treatment plans left on my voicemail. Please leave me a message to call your office instead.

This authorization will expire two years from signature unless otherwise indicated below:

☐ Indefinite Ends on Date: _________________

Signature: _________________________________ Date: ______________