Thornton Family Dental Care

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ SSN# _____
Last first MI

Address _____ Home# _____

City _____ State _____ Zip _____ Cell# _____

E-mail _____ Work # _____
***This will only be used for appointment confirmations and yearly newsletters from THIS office.*

Sex ☐ Male ☐ Female Age _____ Birthdate _____

☐Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Address _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Phone# _____

Primary Insurance

Subscribers Name _____
Last first MI

Relation to Patient _____ Birthdate _____ SSN# _____

Address *(if different from patient)* _____ Home# _____

Employed by _____ Phone# _____

Insurance Company _____ Phone# _____

Subscriber or ID # _____ Group# _____

Secondary Insurance

Subscriber Name _____ Relation _____

Birthdate _____ SSN# _____

Employed by _____ Phone# _____

Insurance Company _____ Phone# _____

Subscriber or ID # _____ Group# _____

Please complete both sides

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Address _____ Phone # _____
Date of last dental care _____ Date of last dental x-rays _____

Check if you have had problems with any of the following:

☐Bad breath	☐Food collection between teeth	☐Periodontal treatment	☐Sensitivity to Sweets
☐Bleeding gums	☐Grinding or clenching teeth	☐Sensitivity to cold	☐Sensitivity when biting
☐Clicking or popping jaw	☐Loose teeth or broken fillings	☐Sensitivity to hot	☐Sore or growths in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐ N
Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone # _____
Date of last visit _____ Have you had any serious illness or operations? ☐ Y ☐ N
If yes, describe _____
Are you currently under physician care? ☐ Y ☐ N If yes, describe _____
Have you ever had a blood transfusion? ☐ Y ☐ N If yes, give approximate dates _____
Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N Taking birth control pills? ☐Y ☐ N

Check if you have had any of the following:

☐AIDS/HIV Positive	☐Cough, persistent	☐Hepatitis	☐Rheumatic/Scarlet fever
☐Anaphylaxis	☐Cough up blood	☐High Blood Pressure	☐Shingles
☐Anemia	☐Diabetes	☐Jaw pain	☐Shortness of breath
☐Arthritis, Rheumatism	☐Epilepsy	☐Kidney disease or malfunction	☐Skin rash
☐Artificial heart valves	☐Fainting		☐Spina Bifida
☐Artificial joints	☐Food allergies	☐Liver disease	☐Stroke
☐Asthma	☐Glaucoma	☐Material allergies (**latex**, wool, metal, chemicals)	☐Surgical implant
☐Atopic (allergy prone)	☐Headaches		☐Swelling of feet or ankles
☐Back problems	☐Heart murmur	☐Mitral valve problems	☐Thyroid disease or malfunction
☐Blood Disease	☐Heart problems	☐Nervous problems	
☐Cancer	Describe_____	☐Pacemaker/Heart surgery	☐Tobacco habit
☐Chemical dependency	_____	☐Psychiatric care	☐Tonsillitis
☐Chemotherapy	☐Hemophillia/Abnormal bleeding	☐Rapid weight gain or loss	☐Tuberculosis
☐Circulatory problems		☐Radiation treatment	☐Ulcer/Colitis
☐Cortisone treatments	☐Herpes	☐Respiratory disease	☐Venereal disease

List medications you are currently taking, if any: _____
_____
List drug allergies, if any: _____
_____

Check if you have taken or are currently taking the following medications:

☐Aredia ☐Actonel ☐Zometa ☐Fosamax ☐No, none of these drugs

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.