



Fara Thomas, D.D.S.

Preventative • Restorative • Cosmetic Dentistry

Patient Information

Home Phone:		Work Phone:		Cell Phone:	
Email:			Best Contact-Reminder Method Email <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/>		
Name	First:	MI:	Last:	SSN:	- -
Address:			City:	State:	Zip:
Sex:	M <input type="checkbox"/> F <input type="checkbox"/>	Birth Date:	Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		
Employer:			Occupation:		
Emergency Contact:		Relationship:		Phone:	

How Did You Hear About Us

Sign <input type="checkbox"/> Postcard <input type="checkbox"/> Magazine <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Other <input type="checkbox"/> (explain)	
Doctor Referral <input type="checkbox"/> (name)	Patient Referral <input type="checkbox"/> (name)

Dental Insurance Information

Name of Insured:		Relationship to Patient:		
Insured's Birth Date:	SSN:	- -	Employer:	
Group Number:		Policy or I.D. Number:		
Insurance Company:			Phone:	
Address:		City:	State:	Zip:
Deductible: \$	Annual Benefit: \$	Annual Benefit Remaining: \$		

Do You Have Secondary Dental Insurance: Yes No (if yes, please complete the following)

Name of Insured:		Relationship to Patient:		
Insured's Birth Date:	SSN:	- -	Employer:	
Group Number:		Policy or I.D. Number:		
Insurance Company:			Phone:	
Address:		City:	State:	Zip:
Deductible: \$	Annual Benefit: \$	Annual Benefit Remaining: \$		

Information Release Authorization

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if minor): **X**

Date:

Dental Health History

Name	First:	MI:	Last:	SSN:	- -
Name of Previous Dentist:				Date of Last Exam:	
Reason for Today's Visit:					
How Often Do You Brush:			How Often Do You Floss:		
What texture toothbrush do you use: Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard <input type="checkbox"/>					
Do you feel pain to any of your teeth when brushing or flossing them:	Y <input type="checkbox"/> N <input type="checkbox"/>	Have you had any head, neck, or jaw injuries:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Do your gums bleed while brushing:	Y <input type="checkbox"/> N <input type="checkbox"/>	Do you have frequent headaches:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Do your gums bleed when flossing:	Y <input type="checkbox"/> N <input type="checkbox"/>	Do you clench or grind your teeth:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Are your teeth sensitive to hot, cold, sweet or sour foods or liquids:	Y <input type="checkbox"/> N <input type="checkbox"/>	Have you ever had an upsetting experience in the dental office:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Have you noticed any loosening of your teeth:	Y <input type="checkbox"/> N <input type="checkbox"/>	Are you satisfied with the appearance of your teeth:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Does food tend to become caught between your teeth:	Y <input type="checkbox"/> N <input type="checkbox"/>	Have you ever had;	Y <input type="checkbox"/> N <input type="checkbox"/>		
Do you have any sores or lumps in or near your mouth:	Y <input type="checkbox"/> N <input type="checkbox"/>	Orthodontic treatment (Braces):	Y <input type="checkbox"/> N <input type="checkbox"/>		
Have you ever experienced any of the following problems in your jaw;		Oral surgery:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Clicking:	Y <input type="checkbox"/> N <input type="checkbox"/>	Your teeth ground or the bite adjusted:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Pain (joint, ear, side of face):	Y <input type="checkbox"/> N <input type="checkbox"/>	A bite plate or other appliance:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Difficulty opening/closing:	Y <input type="checkbox"/> N <input type="checkbox"/>	Do you bite your lips or cheeks frequently:	Y <input type="checkbox"/> N <input type="checkbox"/>		
Is there anything about having dental treatment that bothers you (if yes explain):			Y <input type="checkbox"/> N <input type="checkbox"/>		
What Would You Like To Change About Your Smile:					

Medical Health History

Are you in good health:	Y <input type="checkbox"/> N <input type="checkbox"/>	Are you allergic to or have any reactions to;	
Are you wearing contact lenses:	Y <input type="checkbox"/> N <input type="checkbox"/>	Local anesthetics like novocaine:	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you use cocaine or other drugs:	Y <input type="checkbox"/> N <input type="checkbox"/>	Penicillin:	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you use alcohol:	Y <input type="checkbox"/> N <input type="checkbox"/>	Sulfa drugs:	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you use tobacco:	Y <input type="checkbox"/> N <input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills:	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you bruise easily:	Y <input type="checkbox"/> N <input type="checkbox"/>	Aspirin:	Y <input type="checkbox"/> N <input type="checkbox"/>
Do you have abnormal bleeding:	Y <input type="checkbox"/> N <input type="checkbox"/>	Iodine:	Y <input type="checkbox"/> N <input type="checkbox"/>
Have you ever taken Phen Fen:	Y <input type="checkbox"/> N <input type="checkbox"/>	Latex:	Y <input type="checkbox"/> N <input type="checkbox"/>
Have you had recent weight loss:	Y <input type="checkbox"/> N <input type="checkbox"/>	Other antibiotics:	
Have you ever had a blood transfusion:	Y <input type="checkbox"/> N <input type="checkbox"/>	Other allergies:	
Have there been any changes in your general health within the past year, if so explain:	Y <input type="checkbox"/> N <input type="checkbox"/>	Are you currently taking any medication(s) including nonprescription medicine, if so list here:	Y <input type="checkbox"/> N <input type="checkbox"/>
Have you been hospitalized for any serious illness or surgery, if so explain:	Y <input type="checkbox"/> N <input type="checkbox"/>	Are you currently taking any diet pills or herbs, if so list here:	Y <input type="checkbox"/> N <input type="checkbox"/>
Are you now under the care of a physician:	Y <input type="checkbox"/> N <input type="checkbox"/>	When was you last physical exam:	

Medical Health History Continued...

Name	First:	MI:	Last:	SSN:	- -
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Do you have, or have you ever had, any of the following:

Rheumatic heart disease or rheumatic fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/>	N <input type="checkbox"/>
Scarlet fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	AIDS or HIV infection	Y <input type="checkbox"/>	N <input type="checkbox"/>
Heart defect or heart murmur	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sinus trouble	Y <input type="checkbox"/>	N <input type="checkbox"/>
Mitral valve prolapse	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid problems	Y <input type="checkbox"/>	N <input type="checkbox"/>
Heart trouble, heart attack, or angina	Y <input type="checkbox"/>	N <input type="checkbox"/>	Allergies	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do you have chest pain upon exertion	Y <input type="checkbox"/>	N <input type="checkbox"/>	Arthritis or rheumatism	Y <input type="checkbox"/>	N <input type="checkbox"/>
Are you short of breath after mild exercise	Y <input type="checkbox"/>	N <input type="checkbox"/>	Joint replacement or implant	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do your ankles swell	Y <input type="checkbox"/>	N <input type="checkbox"/>	Stomach ulcer	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do you get short of breath when you lie down	Y <input type="checkbox"/>	N <input type="checkbox"/>	Kidney trouble	Y <input type="checkbox"/>	N <input type="checkbox"/>
Do you require extra pillows when you sleep	Y <input type="checkbox"/>	N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/>	N <input type="checkbox"/>
Pacemaker	Y <input type="checkbox"/>	N <input type="checkbox"/>	Persistent cough	Y <input type="checkbox"/>	N <input type="checkbox"/>
Heart surgery	Y <input type="checkbox"/>	N <input type="checkbox"/>	Cough that produces blood	Y <input type="checkbox"/>	N <input type="checkbox"/>
High blood pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>
Low blood pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sexually transmitted disease	Y <input type="checkbox"/>	N <input type="checkbox"/>
Hepatitis	Y <input type="checkbox"/>	N <input type="checkbox"/>	Epilepsy	Y <input type="checkbox"/>	N <input type="checkbox"/>
Jaundice	Y <input type="checkbox"/>	N <input type="checkbox"/>	Anemia	Y <input type="checkbox"/>	N <input type="checkbox"/>
Liver disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	Leukemia	Y <input type="checkbox"/>	N <input type="checkbox"/>
Stroke	Y <input type="checkbox"/>	N <input type="checkbox"/>	Glaucoma	Y <input type="checkbox"/>	N <input type="checkbox"/>
Lung or breathing problems	Y <input type="checkbox"/>	N <input type="checkbox"/>	Eating Disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/>	N <input type="checkbox"/>	Are you pregnant or think you may be	Y <input type="checkbox"/>	N <input type="checkbox"/>
Hay fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	Are you nursing	Y <input type="checkbox"/>	N <input type="checkbox"/>
Hives or skin rash	Y <input type="checkbox"/>	N <input type="checkbox"/>	Are you taking birth control pills	Y <input type="checkbox"/>	N <input type="checkbox"/>
Fainting spells or seizures	Y <input type="checkbox"/>	N <input type="checkbox"/>			

Do you have any medical condition not listed above, that you think we should know about, if so explain:

Physicians Name:	Phone:
Address:	City: State: Zip:

I certify that I have read and understand the above questions and information, and I have accurately answered these questions to the best of my knowledge. I also understand that providing incorrect information can be dangerous to my health. It is my responsibility to adequately inform the dental office of any changes in my medical status.

Signature of Patient (or parent if minor): **X**

Date:

For Office Use Only

Summary of Dental Health:

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Summary of Medical Health:

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Medical Health Update:		Initials:		
Date	Comments	Patient	Dentist	Hygienist

Financial Policy

Name	First:	MI:	Last:	SSN:	-	-
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We are pleased that you have chosen our office for your dental needs. The following information is provided to assist you in understanding our services and financial policies.

Dental insurance is a contract between the insured and the dental insurance company. We accept most dental insurance and as a courtesy will assist you with maximizing your dental insurance reimbursement, however, each patient is responsible for all fees incurred, should their dental insurance benefits be less than expected. We require that arrangements for payment of your estimated share be made at the time of service.

Please remember that our office does not diagnose problems or recommend treatment based on the benefits provided by your dental insurance company.

Regardless of dental insurance coverage and limitations, the patient or guardian is ultimately responsible for all fees for services rendered. Unpaid balances will accrue at 18% annual interest rate after 60 days from the date of service. The patient or guardian will be responsible for all collection costs, including collection agency fees, court costs, and attorney's fees.

We realize that with larger treatment plans, other payment arrangements may be necessary. Financing options are available through Care Credit. Our office will provide you with this information and discuss other ways to make your dentistry more affordable.

I hereby authorize Fara Thomas, D.D.S., to keep my signature on file and to charge my credit card for any delinquent account balances (past due by 30 days) I have not paid. I understand that as a courtesy, any account credits may also be refunded back onto my account, and reasonable effort will be made to advise me prior to either.

<input type="checkbox"/> Visa	Card Number:	Exp. Date:	Security Number:
<input type="checkbox"/> MasterCard			

Cardholder Signature: **X**

Date:

Insurance Estimate Policy

Any insurance benefit estimates provided by our office or its employees are based on average benefits provided by insurance companies. Each patient is ultimately responsible for determining their particular insurance coverage, benefits, and insurance policy limitations. This office recommends that each patient contact their insurance company prior to any dental treatment, to fully review their particular dental insurance coverage, benefits, and insurance policy limitations. Each patient agrees to be fully responsible for any fees accrued, regardless of any estimated fee inaccuracies provided by this office or its employees.

Appointment Policy

If you are ever unable to keep an appointment you have scheduled with us, please notify us at least **48 hours in advance**. This allows us the opportunity to schedule another patient. We reserve the right to charge a **\$75 per hour fee**, for each scheduled hour or increment thereof, for all missed appointments and short notice cancellations. If short notice cancellations or "no shows" become excessive (3 maximum), you may be required to pre pay for your dental visits before being rescheduled.

I certify that I have read, understand and agree, with these financial, insurance estimate, and appointment policies.

Signature of Patient (or parent if minor): **X**

Date: