

**Patient**

Patient's Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Previous/Current Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Other Family Members Seen by us? \_\_\_\_\_

**Spouse or Responsible Party**

The following is for:  the patient's spouse  the responsible party

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Employment Information**

The following is for:  the patient  the responsible party

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

**Contact in Case of Emergency**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_



# Insurance Information

## Primary

Name of Insured: \_\_\_\_\_ Is insured a patient? Yes No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Insured's Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's relationship to insured: Self Spouse Child Other: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

## Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient? Yes No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Insured's Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Patient's relationship to insured: Self Spouse Child Other: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_



## 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 physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever 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 ever 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 controlled substances?  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?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa drugs
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Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever 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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



### Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

### Appointments

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a **24-hour notice** is expected. A fee may be applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

### Insurance

A courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, **we do require you to pay your deductible and/or "estimated patient portion" at the time of service.** The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of basic procedures and 50% of major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental insurance benefits. \_\_\_\_\_

### Usual and Customary Rates

Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates or have time limitations imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. **You are responsible for any balance left unpaid by your insurance company.** The adult accompanying a minor is responsible for full payment.

**PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, CREDIT AND DEBIT CARDS.**

Thank you for understanding our guidelines. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above office and financial policies.

X \_\_\_\_\_  
Signature of patient or responsibility party

\_\_\_\_\_  
Date





### HIPAA DISCLOSURE AUTHORIZATION FORM

Full Name \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to use or disclose my  
(Discloser)

protected health information related to \_\_\_\_\_  
(Type of Information)

to \_\_\_\_\_ for the following purpose:  
(Recipient)

\_\_\_\_\_  
\_\_\_\_\_

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

\_\_\_\_\_  
Date Signature of Individual or Representative

\_\_\_\_\_  
Authority or Relationship to Individual, if Representative

EXPIRATION DATE: This authorization will expire on \_\_\_\_\_  
If no date or event is stated, the expiration date will be six years from the date of this authorization.

COPY PROVIDED: The subject of this authorization shall receive a copy of this authorization, when signed.





**Thank you for choosing Thayer Dental Care for you and your family's dental needs. Please take a moment to let us know where you heard about our office.**

- Ozark Horse Trader
- Areawide Media
- Social Media
- Friend/ Family Member \_\_\_\_\_
- Thayer Dental Care Website
- Teeth Tomorrow Website
- Online (Google, Yahoo, etc.)
- Phonebook
- Billboard
- Insurance
- TV Commercial
- 417 Magazine
- Avenues Magazine
- Post Card/Flyer
- Other \_\_\_\_\_

