JULIAN THOMAS
DMD, PA
*Family & Cosmetic Dentistry*

## PATIENT INFORMATION

Patient Name _____

Name I Prefer _____

Social Security # _____

Driver's License # _____

Address _____

City _____

State _____ Zip _____

Sex _____ Age _____

Birthdate _____ ◉ Single ☐ Married ☐ Minor

Patient Employer _____

Employer Address _____

_____

**Spouse's Name** _____

Birthdate _____

Social Security # _____

Employer _____

**Reason for today's visit**

_____

**How did you find out about Dr. Thomas?**

_____

## DENTAL INSURANCE

**Primary** Insurance Information:

Subscriber's Name _____

Birthdate _____ SS # _____

Insurance Co. _____

Group # _____

**Secondary** Insurance Information:

Subscriber's Name _____

Birthdate _____ SS # _____

Insurance Co. _____

Group # _____

**Assignment and Release**

I certify that I, and/or my dependents(s), have insurance coverage with the above company(ies) and assign directly to Dr. Julian Thomas all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Julian Thomas may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name

_____ _____

Date Relationship to Patient

## CONTACT INFO

**E-mail** _____ *(confidential, for confirmation purposes only)*

Home Phone _____ Work Phone _____ Cell _____

Spouse's Work _____ Spouse's Cell _____

**In case of emergency, contact** *(someone who does not live in your household)*

Name _____ Relationship _____

Home Phone _____ Other Phone _____

## DENTAL/HEALTH HISTORY

Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
Medical Physician's Name: _____
Phone #: _____

**Do you require antibiotics before dental treatment?** ○ Yes ○ No
Do you smoke or use tobacco in any other form? ○ Yes ○ No
**For Women:** Are you taking birth control pills? ○ Yes ○ No
**Are you pregnant?** ○ Yes ○ No
Comments: _____

**Do you or have you experienced the following?** (circle all that apply)

- ☐ Abnormal Bleeding
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Tuberculosis (TB)

## MEDICATIONS

List any medications you are currently taking and the correlation diagnosis: _____

_____

_____

_____

Pharmacy Name _____ Phone _____

## ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

## *Authorization*

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. As a courtesy, we will file your dental insurance as an out of network provider. **I understand that I am responsible for payment of services rendered, regardless of my insurance benefit.** I understand I am responsible for all late charges after 45 days and collection and attorney fees for unpaid balances.

**INITIAL:** _____

**Privacy Practices Acknowledgement**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**INITIAL:** _____

**BROKEN OR CANCELED APPOINTMENT POLICY**

Any appointment that is broken or canceled without a 24 hour notice will be charged a fee of $50 per hour scheduled. We are sympathetic to unavoidable emergencies. In order to avoid your account being charged, our office must receive notice at least 24 hours in advance should it be necessary to reschedule your appointment by phone, voicemail, or email.

**INITIAL:** _____

_____ _____
**Signature** **Date**

*Please use the Submit by Email button at the top right of this document to submit via email, or simply print and bring with you to your first visit. You can also fax to: 864.676.0346*