# PATIENT INFORMATION AND MEDICAL RECORD
# RONALD A. THOMPSON JR., D.D.S.

**PLEASE PRINT** Date: _____

Name _____ Soc. Sec. No. _____
Address _____ Home Phone _____ Cell _____
City _____ Zip Code _____ E-Mail _____
Birth Date _____ Age _____ Weight _____ Marital Status: Single _____ Married _____
Patient's Employer _____ Occupation _____
Employer's Address _____ Work Phone _____
If Insurance, Cardholder's Name _____ Cardholder's Soc. Sec. No. ___/___/___
Cardholder's Birth Date ___/___/___

Dental Insurance Co. _____
Medical Insurance Co. _____
Name of Spouse or Parent (if a minor) _____
Spouse/Parent's Employer _____ Occupation _____
Spouse/Parent Employer Address _____ Phone _____
Referred by (Name) _____ Dentist ____ Family Member ____ Friend ____
Your Physician's Name _____ Your Dentist's Name _____
Have you ever been a patient in our office? _____
Name of other family members who have been patients in our office _____
If you are having a tooth extracted, are you considering a dental implant in the future to replace this tooth? . . . . . YES NO

## HEALTH QUESTIONS (CIRCLE)

1. Is your general health good? . . . . . YES NO
2. Are you allergic to any medication? . . . . . YES NO
   If Yes, list medication(s) _____
3. Are you under a physician's care now? . . . . . YES NO
   If Yes, list reason(s) _____
4. Have you ever had trouble with bleeding after surgery? . . . . . YES NO
5. Do you now take or have you ever taken oral Fosamax, Actonel or Boniva / or received a yearly injection of Reclast? (All of these are used to increase bone hardness) If yes, please circle which one. . . . . YES NO
6. Have you ever been given intravenous Zometa, Aredia or any other bisphosphonates that are used to increase bone hardness? If yes, please circle which one. . . . . YES NO
7. Have you ever had a general anesthetic? . . . . . YES NO
8. Do you smoke or chew tobacco? . . . . . YES NO
9. (Female) Are you pregnant? . . . . . YES NO
10. Are you now or have you ever been addicted to drugs? . . . . . YES NO
11. Circle any of the following which you have had:

| | | | | |
|---|---|---|---|---|
| Heart Trouble | Liver Problem | Heart Murmur | HIV Infection | Prolonged Bleeding |
| Blood Disease | Epilepsy | Cancer | Hepatitis | High Blood Pressure |
| AIDS | Arthritis | Asthma | Diabetes | Psychiatric Treatment |
| Kidney Trouble | Emphysema | Anemia | Stomach Problem | Ulcers |
| Rheumatic Fever | Lung Problem | Stroke | Venereal Disease | Joint Replacement |
| Yellow Jaundice | Tuberculosis | Glaucoma | Breathing Problem | Latex Allergy |

Other Medical conditions (Please list) _____
12. List all medications you are taking: _____

**(OVER) There are 3 places to sign and date on the back of this sheet.**

## IF YOU HAVE INSURANCE

If I have insurance, I understand that after 60 days this office will send me a statement expecting that the remainder of my balance be paid in full regardless of the status of my insurance claim. (A credit card form is available to make this work for you without receiving a statement). Afterwards if the insurance company pays an additional amount to the office the appropriate reimbursement will be sent to me.

| Signature of Responsible Party | Relationship to Patient, if Minor | Date |
|---|---|---|

## FEE STATEMENT

I accept full financial responsibility for the treatment performed by this office. I understand that insurance forms will be completed and filed as a convenience to the patient. However, I understand that the ultimate responsibility for all financial obligations lies not with any third party, but with the patient. The patient is also responsible for any and all costs of collection, including attorney's fees involved with the collection, should this situation arise.

| Signature of Responsible Party | Relationship to Patient, if Minor | Date |
|---|---|---|

We will be happy to discuss our financial policies with you. Please ask us should any question arise.
***Thank You!***

Patient's or authorized person's signature (Read before signing). I authorize the release of any medical/dental information to process this claim. I also request payment of Government benefits either to myself or the party who accepts assignments below. I authorize payment of medical/dental benefits otherwise payable to me to the undersigned physician or supplier for service described below.

Signed: _____ Date: _____

Signature of Responsible Party