FRED THOMPSON DDS

RECONSTRUCTIVE GENERAL DENTISTRY

COSMETIC, IMPLANT AND ORAL SURGERY

Patient Information

Date_____ Whom may we thank for referring you?_____

Name_____ SS #_____

Last Name First Name Initial

*I prefer to be called*_____ DL #_____

Is there an existing family member's account you wish to be added to?

If so, who _____

Name of account holder

Address_____

City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

Email Address_____

As a courtesy, we offer appointment confirmation via email, text message or by phone.
Please inform us of your preference:

☐ *Email* ☐ *Text Message* ☐ *Home Phone* ☐ *Work Phone* ☐ *Cell Phone*

Sex ☐ M ☐ F Date of Birth _____ ☐ Single ☐ Married

Patient's Employer_____ Occupation_____

Notify in case of emergency_____ Contact #_____

Responsible Party (if different from patient)

Person Responsible for Account_____

Last Name First Name Initial

Relationship to Patient_____ Date of Birth_____ SS #:_____

Address_____
(If different from patient)

City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

Email Address_____

Dental History

Name of Previous Dentist_____ City_____

Why did you leave your last dentist?_____

Are you happy with the appearance and color of your teeth?_____

Have you ever had jaw or TMJ surgery?_____

Can we help you with something specific today or are you interested in hearing about a lifetime plan?_____

_____

_____

Are you interested in sleep and/or sedation dentistry? ☐ yes ☐ no

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DENTAL PLAN INFORMATION

Date_____

Patient Name_____ Date of Birth_____

Subscriber's Name_____ Relationship to Patient_____

Subscriber's Date of Birth_____ Subscriber's SS#_____

Subscriber's Employer_____

Dental Plan Name_____

Dental Plan Address_____

Insurance Company Phone #_____

Group #_____ Employee/ID #_____

If patient is a student, name of school/college_____

AUTHORIZATION AND RELEASE

I authorize Dr. Thompson, his associates or assigns permission to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to any other healthcare practitioners as necessary for treatment and/or to third party payers.

Please be aware that we can not guarantee any estimate and that there may be a balance after insurance pays. *Rarely does an insurance plan cover 100% of your dental treatment.* We will do our best to estimate your deductible and insurance co-payment. However, any remaining balance is your direct responsibility. I agree to be responsible for payment of all services rendered on my behalf or my dependents. For your convenience, we accept cash, check and credit cards. We also offer extended payment plans through Care Credit financing.

_____ _____

Signature – patient, parent or guardian Date

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COSMETIC, IMPLANT AND ORAL SURGERY

Medical History **Date of Birth**_____

Patient Name_____ **Preferred Name**_____

Last Name **First Name** **Initial**

Physician's Name_____ **Office #**_____

Specialist's Name_____ **Office #**_____

ALLERGIES

Latex ☐ **yes** ☐ **no**

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Local Anesthetics**

☐ **Other** **If so, please explain** _____

Do you require a pre-operative antibiotic before dental treatment ☐ **yes** ☐ **no**

If yes, reason_____

Medications	Dosage	Reason

PAST AND CURRENT MEDICAL CONDITIONS (*mark all that apply)*

☐ AIDS/HIV Positive
☐ Alzheimer's disease
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Asthma
☐ Blood Transfusion
☐ Breathing Problems
☐ Cancer
☐ Chemotherapy
☐ Congenital Heart Disorder
☐ Diabetes
☐ Drug Addiction
☐ Emphysema
☐ Epilepsy or Seizures
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Hepatitis A – C
☐ Frequent Mouth Ulcers
☐ High Blood Pressure
☐ Irregular Heartbeat
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Radiation Treatments
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers

For WOMEN

☐ Are you pregnant? Week #_____ ☐ Are you nursing?

Are there any other conditions you feel the doctor should know about?_____

_____

Is there anything you would like to speak privately to the doctor about? ☐ yes ☐ no

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_____

SUBMIT

FRED THOMPSON DDS
RECONSTRUCTIVE GENERAL DENTISTRY
610 Old Campbell Road, Suite 116
Richardson, TX 75080

Notice of Privacy Procedures for Protected Health Information

I acknowledge that I have been provided with the Notice of Privacy Practices for Protected Health Information. This notice explains how:

- Fred Thompson DDS will only use my health information for the purposes of treatment or payment for my treatment, and Fred Thompson DDS health care operation.
- This notice will also explain in more detail how Fred Thompson DDS will only use and share my health information for other than treatment, payment, and health care operations.
- Fred Thompson DDS will only use and share my health information as required/permitted by law.

Patient's complete legal name_____
(Please print)
Patient's SSN_____ Patient's DOB_____

Signature_____Date_____

Relationship of legally authorized representative to patient _____