Welcome to Our Office
Mark A. Thompson, DDS, MS
PATIENT INFORMATION

PATIENT'S FULL NAME: NICKNAME:

DATE OF BIRTH: AGE: SOCIAL SECURITY #:

PHYSICAL ADDRESS:

CITY, STATE, ZIP:

MAILING ADDRESS: CITY, STATE, ZIP:

HOME #: WORK #: CELL #:

EMPLOYER: OCCUPATION:

HOW DID YOU HEAR ABOUT OUR OFFICE?

MARITAL STATUS: ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ SEPARATED

SPOUSE'S FULL NAME: NICKNAME:

RELATIONSHIP TO PATIENT: DATE OF BIRTH:

ADDRESS (IF DIFFERENT):

CITY, STATE, ZIP:

EMPLOYER: OCCUPATION:

HOME #: WORK #: CELL #:

INSURANCE INFORMATION

SUBSCRIBER'S NAME: DATE OF BIRTH:

SS #: GROUP #: INSURED'S EMPLOYER:

INSURANCE COMPANY NAME: PHONE #:

ADDRESS: CITY, STATE, ZIP:

DO YOU HAVE DUAL COVERAGE: ☐ YES ☐ NO IF YES, PLEASE CONTINUE

FOR DOCTOR'S OFFICE USE ONLY.	EFFECTIVE DATE:_____DEDUCTIBLE $:_____PERCENTAGE:_____CONTACT NAME:_____ LIMIT/MAX: $_____ADULT AGE LIMIT:_____ DEPENDENT AGE LIMIT:_____ AMOUNT USED:_____ PAYMENT METHOD: AUTO/MANUAL = MONTHLY / QUARTERLY / BI-ANNUALLY / ANNUALLY / AT END OF TREATMENT

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

ADDRESS: HOME #:

CITY, STATE, ZIP: RELATIONSHIP TO PATIENT:

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS BEFORE EXTENDING CREDIT FOR TREATMENT FEES AND MAY, AT THE DISCRETION OF THE OFFICE, USE THE SERVICES OF A CREDIT REPORTING SERVICE.

SIGNATURE: **DATE:**

WHO IS YOUR CURRENT DENTIST?

DATE OF LAST CLEANING AND/OR CHECKUP?

HAVE YOU EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT?

DOCTOR'S NAME DATE OF TREATMENT

HAVE THERE BEEN ANY INJURIES TO THE FACE, TEETH, MOUTH OR CHIN?

IF SO, EXPLAIN

HAVE YOU EXHIBITED ANY OF THE FOLLOWING HABITS/CONDITIONS?

	Past habit	Current habit		Past habit	Current habit
THUMB SUCKING	❑	❑	LIP BITING	❑	❑
FINGER SUCKING	❑	❑	NAIL BITING	❑	❑
MOUTH BREATHING	❑	❑	GRINDING OF TEETH	❑	❑
TONGUE THRUSTING	❑	❑	SNORING	❑	❑

HAVE YOU EXPERIENCED JAW POPPING OR HAS YOUR JAW EVER LOCKED?

DO YOU HAVE FREQUENT HEADACHES?

ARE YOU UNDER THE CARE OF A PHYSICIAN?

IF YES, PHYSICIAN'S NAME

PLEASE LIST ALL THE DRUGS/SUPPLEMENTS YOU ARE TAKING AND FOR WHAT PURPOSE.

	DRUG / SUPPLEMENT	PURPOSE
1.		
2.		
3.		

PLEASE LIST THE DRUGS TO WHICH YOU ARE ALLERGIC :

DO YOU HAVE A HEART CONDITION/MURMUR REQUIRING ANTIBIOTIC COVERAGE FOR DENTAL WORK?

HAVE YOU HAD YOUR TONSILS OR ADENOIDS REMOVED?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

ASTHMA	YES	NO	DIABETES	YES	NO
SINUS INFECTION	YES	NO	HEPATITIS/JAUNDICE	YES	NO
HEART TROUBLE	YES	NO	HIV / AIDS	YES	NO
RHEUMATIC FEVER	YES	NO	GLANDULAR DISORDERS	YES	NO
ALLERGIES?	YES	NO	OTHER MEDICAL		
TO_____			CONDITIONS NOT LISTED	YES	NO

IF YES, EXPLAIN

I UNDERSTAND THE INFORMATION GIVEN IS CORRECT AND WILL BE HELD IN THE STRICTEST CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE **DATE:**