



Thayer Dental Clinic

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

- Ozark Horse Trader
- Areawide Media
- Facebook
- Friend or Family member (please name) _____
- Thayer Dental Clinic website
- Online (i.e. Google, Yahoo, etc)
- Phonebook
- Postcard
- Billboard
- Insurance
- TV Commercial

To the best of my knowledge, the questions on my medical history 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 _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I, _____, accept financial responsibility for all dental procedures that will be performed on my behalf by this office. If my insurance carrier(s) deny my claims, or make payments to me. I accept full responsibility, and will reimburse Thayer Dental Clinic for all charges.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. The Notice of Privacy Practices will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

You may request to read this notice or waive the offer and know that this information is available to you at any time during regular office hours. If you choose to read the Privacy Practices Notice, please review it carefully.

Please sign below stating you have read the options listed above and understand your rights.

Patients Name: _____ Today's Date: _____

Patients Signature: _____ Date of Birth: _____

Person or Persons we may release your medical/dental information to.

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc Sec: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____
City: _____ State / Zip: _____ Pager: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc Sec: _____
E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID: _____ Pref. Dentist: _____
Employer ID: _____ Pref. Pharmacy: _____
Carrier ID: _____ Pref. Hyg: _____

Referred By _____
Previous Dentist _____
Emergency Contact _____
Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____

Thayer Dental Clinic
Eaglesoft Medical History
 Birth Date: _____

Patient Name: _____

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 _____

Have you ever been hospitalized or had a major operation? Yes No If yes _____

Have you ever had a serious head or neck injury? Yes No If yes _____

Are you taking any medications, pills, or drugs? Yes No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

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

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

Have you ever had any serious illness not listed Yes No If yes _____

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: _____

X

Date: _____