Patient Registration

First Name: ______________ Last Name: ______________ Middle Initial: ______

Patient is: ☐ Policy Holder Preferred Name: ______________
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______________ Last Name: ______________ Middle Initial: ______
Address: ______________ Address 2: ______________
City, State, Zip: ______________
Home Phone: ______________ Work Phone: ______________ Ext: ______ Cellular: ______________
Birth Date: ______________ Soc. Sec.: ______________ Driver's Lic.: ______________
☐ Responsible Party is also a Policy Holder for a Patient ☐ Primary Insurance Policy Holder
☐ Secondary Insurance Policy Holder

Patient Information

Address: ______________ Address 2: ______________
City, State, Zip: ______________
Home Phone: ______________ Work Phone: ______________ Ext: ______
Cellular: ______________ ☐ I would like to receive correspondence via text.
Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth Date: ______________ Age: ______ Soc. Sec.: ______________
Driver's Lic.: ______________ E-mail: ______________
☐ I would like to receive correspondence via e-mail.

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired
Student Status: ☐ Full Time ☐ Part Time
Medicaid ID: ______________ Employer: ______________
Employer ID: ______________ Pref. Pharmacy: ______________
Carrier ID: ______________

Last Physician Visit: ______________
Name of Physician: ______________
Previous Dentist: ______________
City, State: ______________
Last Dental Exam: ______________
Who referred you? ______________

Primary Insurance Information

Name of Insured: ______________
Insured SSN: ______________
Insured Birth Date: ______________
Employer: ______________
Ins. Company: ______________
Address: ______________
City, State, Zip: ______________

Secondary Insurance? Yes ☐ No ☐

Name of Insured: ______________
Insured SSN: ______________
Insured Birth Date: ______________
Employer: ______________
Ins. Company: ______________
Address: ______________
City, State, Zip: ______________

Do you have a preference for provider? Yes ☐ No ☐

☐ Dr. F. E. Thomas
☐ Dr. Alicia Bryant-Thomas

Does your insurance plan have a Preferred Provider? Yes ☐ No ☐

☐ Dr. F. E. Thomas
☐ Dr. Alicia Bryant-Thomas

Thomas Dental Center
219 Savannah Avenue Statesboro, GA 30458
Medical History

Patient Name: ________________________________ Birth Date: ______________________

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, please exlain: ________________________________
Have you ever been hospitalized or had a major operation? Yes ☐ No ☐
If yes, please explain: ________________________________
Have you ever had a serious head or neck injury? Yes ☐ No ☐
If yes, please explain: ________________________________
Are you taking any medications, pills, or drugs? Yes ☐ No ☐
If yes, please explain: ________________________________
Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐
If yes, please explain: ________________________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ☐ No ☐
Are you on a special diet? Yes ☐ No ☐
Do you use tobacco? Yes ☐ No ☐
Do you use controlled substances? Yes ☐ No ☐
Women: Are you
Pregnant/ Trying to get pregnant? Yes ☐ No ☐ Taking oral contraceptives? Yes ☐ No ☐
Nursing? Yes ☐ No ☐

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Local Anesthetics ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Other; If yes, please explain: ________________________________

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis/Gout	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Shingles
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Artificial Joint	☐ Excessive Thirst	☐ Hives or Rash	☐ Sinus Trouble
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stroke
☐ Breathing Problem	☐ Frequent Headaches	☐ Liver Disease	☐ Swelling of Limbs
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Tonsillitis
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tumors or Growths
☐ Cold Sores/ Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Ulcers
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Venereal Disease
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? Yes ☐ No ☐
Comments:
____
____
____

FOR OFFICE USE ONLY: Doctor's Initials

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:** ____________________

Financial Responsibility

I understand it is the responsibility of each patient to arrange for payment for the dental services received in this office. I hereby authorize any insurance benefits to be paid directly to Thomas Dental Center and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual accompanying the child for treatment.

Consent for Treatment:

- Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Dentist.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Obtain Medical Records

I hereby authorize Thomas Dental Center to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Consent to Release Medical Information and/or Records to a Spouse, Family Member or Significant Other:

I hereby authorize Thomas Dental Center to release any information contained in my medical record to the person listed:

1)______________________________ 2)______________________________

If you do not authorize information to be released to anyone, please underline this statement.

I do not authorize any information to be released to anyone other than myself.

I hereby authorize messages to be left on a voicemail system or answering machine.
Please indicate the number(s) staff can utilize to leave a message for you:

1)______________________________ 2)______________________________

Acknowledgement of Privacy Rights:

By signing below, I acknowledge that I have received the notice of Privacy Practices and Individual Rights.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature:____ Date:________________________________

I, the undersigned (patient and legally responsible party) authorize treatment to be rendered and assume financial responsibility.

Please know and understand that your dental insurance is a contract between you and your dental insurance company. We file insurance as a courtesy to our patients. It is your responsibility to know and understand what your dental insurance covers and does not cover.

I understand that I am responsible for my co-pay and any balance not paid by my insurance company.

I acknowledge that all non-current balances on accounts over sixty days will be charged a service charge of 1.5% per month on the unpaid balance. Any additional costs incurred in collecting on this account will be added to your balance due and will be your responsibility.

____

Signature of Person Responsible for the Payment of the Account

Broken Appointments

A specific amount of time is reserved especially for you or your child and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $25 cancellation fee (emergencies are an exception).

☹ Three missed appointments without 24 hour notice will result in dismissal of entire family.
Children 17 years old and younger must be accompanied by a legal parent or guardian.

Signature: ____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address:____

Telephone: ______________________ E-mail: ______________________

Patient Number:______________________ Soc. Sec. ______________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make or your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected heath information.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting:

Contact Person: Thomas Dental Center
Telephone: 912-764-6149 Fax: 912-764-3863
E-mail: thomasdentalcenterga@gmail.com
Address: 219 Savannah Ave. Statesboro, GA 30458

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of our revocation submitted to the Contact Person listed above. Lease understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received our revocation and that we may decline to treat you or to continue treating if you revoke this consent.

SIGNATURE

I, ______________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature:______________________ **Date:**______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:______________________
Relationship to Patient:______________________