



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.: _____	
<input type="checkbox"/> Responsible Party is also a Policy Holder for a Patient			<input type="checkbox"/> Primary Insurance Policy Holder		
<input type="checkbox"/> Secondary Insurance Policy Holder					

Patient Information

Address: _____		Address 2: _____			
City, State, Zip: _____					
Home Phone: _____		Work Phone: _____		Ext: _____	
Cellular: _____		<input type="checkbox"/> I would like to receive correspondence via text.			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Birth Date: _____		Age: _____		Soc. Sec.: _____	
Driver's Lic.: _____		E-mail: _____			
<input type="checkbox"/> I would like to receive correspondence via e-mail.					
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired				Last Physician Visit: _____	
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time				Name of Physician: _____	
Medicaid ID: _____		Employer: _____		Previous Dentist: _____	
Employer ID: _____		Pref. Pharmacy: _____		City, State: _____	
Carrier ID: _____		Last Dental Exam: _____			
Who referred you? _____					

Primary Insurance Information

Secondary Insurance? Yes No

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

Do you have a preference for provider? Yes No Does your insurance plan have a Preferred Provider? Yes No

<input type="checkbox"/> Dr. F. E. Thomas	<input type="checkbox"/> Dr. F. E. Thomas
<input type="checkbox"/> Dr. Alicia Bryant-Thomas	<input type="checkbox"/> 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 explain: _____

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?

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