Welcome to Thornydale Dental

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help. We look forward to working with you in maintaining your dental health.

Name____SSN___________________

First M.I. Last

Address____Phone_______________________

City, State, Zip____ Birth date______________

Sex: M______F______ Email____

Married ____ Single____ Widowed______Divorced______Other______

Employer_________________________Occupation________________Work Phone______________

Emergency Contact____________________________________ Phone_________________________

Whom may we thank for referring you?____

What is your preferred method of contact for appointment reminders? Text ___ Email ___ Phone ____

Primary Insurance:

Policy Holder_________________________________Relationship to patient_____________________

Birth date___________SSN or Member ID#______________________ Group # ___________________

Employer_____________________________________ Occupation____________________________

Insurance Company_________________________________ Phone____________________________

SecondaryInsurance:

Policy Holder_________________________________ Relationship to patient____________________

Birth date__________ SSN or Member ID#________________________ Group # _________________

Employer_____________________________________ Occupation___________________________

Insurance Company_______________________________ Phone______________________________

Thornydale Dental

Health History

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.

Question		
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	If yes: ____________________
Do you use tobacco?	☐ Yes ☐ No	If yes: ____________________

Women: Are you:

Pregnant/Trying to get pregnant? ☐ Yes ☐ No   Nursing? ☐ Yes ☐ No   Taking oral contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codiene ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? ☐ Yes ☐ No   If yes: ______________________________

Other? ____

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No   If yes: ______________________________

Please provide your physician's name and contact information along with any additional comments below.

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To the best of my knowledge, the questions on this form have been seriously 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: ____________________

Thornydale Dental

Dental History

Patient Name: ____

- **Please describe the primary reason for you visit and any concerns:**

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Your current dental health is: Good____ Fair____ Poor____ Unsure____

Are you currently having any dental pain? Yes____ No____ Where?___________________________

Do you now or have you had any pain / discomfort in your jaw joint (TMJ)? Yes____ No____

Are you under any new or unusual stress? Yes____ No____

Are your teeth sensitive to cold, heat, sweets, chewing, or anything else? Yes____ No____

Do your gums bleed? Yes____ No____

How often do you: floss ____________________________brush __________________________

Have you ever had gum (periodontal) treatment or surgery? Yes____ No____

If yes, please describe when and what was done.____

Do you have dental implants? Yes___ No___ Do you wear full or partial dentures? Yes___ No____

If yes, are you happy with them? ____

Have you ever suffered from or been told you may have any of the following:

-Gum disease Yes____ No____

-Bruxism or Grinding Yes____ No____

-Jaw Pain or Popping Yes____ No____

-Malocclusion or bite problems Yes____ No____

-Bad Breath Yes____ No____

-Headaches or Migraines Yes____ No____

Do you like your smile? Yes____ No____

If no, what would you like to change? ____

Are you happy with the color of your teeth? Yes____ No____

Have you ever had a serious / difficult problem with any previous dental work? Yes____ No____

Have you ever had an adverse reaction to dental anesthesia (local or nitrous oxide) or a specific dental material?____

Have you ever had any unfavorable dental experiences? Yes____ No____

When was your last dental visit and what was the procedure?____________________________________

Why did you decide to see us today instead of your previous dentist?

____

How can we best accomodate you during your dental visit?______________________________________

Thornydale Dental Financial and Appointment Policies

Financial Policy

Thank you for choosing Thornydale Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is helping you manage your investment in optimal care. In order to prevent potential misunderstandings and maintain practice operations we must inform you that all charges are ultimately the responsibility of the patient and **payment is expected at the time service is provided.**

Payment Options:

-We accept Cash, Check (in state only), Credit Card (Visa, MasterCard, and Discover)

-**Care Credit**: By arrangement with Care Credit, upon credit approval, you can acquire a No Interest payment plan (if paid in full within 6 or 12 months on purchases as per your agreement with CareCredit). Please ask for complete details and allow us to help you submit an application to Care Credit.

All services rendered to you, your dependents, or others assigned by you to your account are charged directly to you, and as such you are personally responsible for payment. If you suspend or terminate treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid, then you will be responsible for all fees incurred to collect. If the account is in default and turned over for collection, a collection fee will be added.

If you utilize dental insurance, then as a courtesy, we will complete all forms and submit your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient and **the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.**

Feel free to ask for the document titled **"Understanding Your Dental Benefits"** for a review of how your insurance benefits may apply. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and deserve.

Appointment Policy

We feel your time is as valuable to you as it is to us. We reserve time to focus on you and your dental health. We do not "overbook" and your appointment time is reserved exclusively for you. If you find it necessary to cancel, then please call our office 48 hours (two business days) prior to your appointment. This courtesy will allow us to be timely for other patients. **If you fail to arrive, or cancel your appointment within 48 hours, we reserve the right to charge you up to $50 per hour missed or may require a deposit to make any future appointments.** After multiple missed or cancelled appointments, you may be dismissed from our practice.

By signing below, I agreee to adhere to Thornydale Dental's Financial and Appointment Policies.

____

Responsible Payor's Signature **Date**

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Please Print Names Of All Patients Assigned to Account

Thornydale Dental

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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