Thodas & Tran
general dentistry

Please complete the following confidential information

PATIENT INFORMATION

Date _____

Home phone _____ Office phone _____

Cell phone _____ Email address _____

Name _____ Employer _____

Address _____ Business Address _____

City _____ Zip Code_____ City _____

Date of Birth _____ Age _____ Position _____

Marital Status _____ Social Security # _____

IF THE PATIENT IS A CHILD

Name of Parent or Guardian _____

School _____ Grade _____

SPOUSE INFORMATION

Name _____ City _____

Employer _____ Business Phone _____ Ext. _____

Business Address _____ Position _____

GENERAL INFORMATION

Convenient appointment time _____ Person responsible for account _____

Are you available for appointment on short notice? _____ Relationship to patient _____

Person to contact for emergency _____ Driver's License # _____

Relationship to patient _____ Bank _____

Their telephone number _____ Branch _____

PRIMARY CARRIER

Name of Insured _____

Date of Birth _____

Social Security # _____

Insurance Carrier Name _____

Insurance Carrier Address _____

Insurance Carrier Phone _____

Employer _____

Union or Local # _____

AID or Group # _____

Date Employed _____

SECONDARY CARRIER

Name of Insured _____

Date of Birth _____

Social Security # _____

Insurance Carrier Name _____

Insurance Carrier Address _____

Insurance Carrier Phone _____

Employer _____

Union or Local # _____

AID or Group # _____

Date Employed _____

PATIENT'S MEDICAL HISTORY • Please answer EACH Question

1. Are you in good health? ☐ Yes ☐ No
2. Date of last physical examination
3. Have you ever been hospitalized? ☐ Yes ☐ No
4. Are you taking any drugs or medication? ☐ Yes ☐ No
   If so, what?
5. Are you sensitive or allergic to any drugs? ☐ Yes ☐ No
   If so, what?
6. Do you have any Immune System deficiencies? ☐ Yes ☐ No
7. Have you ever had a blood transfusion? ☐ Yes ☐ No
   If so, what year?

Physician's name _____

Phone number _____

8. Have you lost or gained more thank 10 pounds in the last year? ☐ Yes ☐ No
9. Are you now under the care of an M.D.? ☐ Yes ☐ No
10. Have you had any serious illness? ☐ Yes ☐ No
11. Blood pressure, if known
12. Do you have any prosthetic replacements? Hip, Joint, Knee, etc. ☐ Yes ☐ No
13. Have you previously taken the dietary drugs known as "fen-phen" (Pondimin, Redux)? ☐ Yes ☐ No
14. Are you allergic to latex? ☐ Yes ☐ No
15. Are you allergic to any metals? ☐ Yes ☐ No
16. Have you ever had a reaction to a local anesthetic (Novocaine, Lidocaine)? ☐ Yes ☐ No

13. Indicate which of the following you have had or have at present. Circle "YES" or "NO" to each item.

Heart Failure	YES	NO	Stroke	YES	NO	Hepatitis A (infectious)	YES	NO
Heart Disease or Attack	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Angina Pectoris	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Cosmetic Surgery	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Pain in Jaw Joints	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Psychiatric Treatment	YES	NO

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes, what month?_____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

Whom may we thank for referring you? _____

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I further understand that a 11/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient signature _____ Date _____ Witness _____

Patient or responsible party _____ Relationship to Patient _____

Who should we contact in case of emergency _____
Name Telephone number

Doctors signature _____

Doctors comments: