Gary A. Thodas
cosmetic & 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: