



MARK H. THOMASSON, D.D.S.
 General Dentistry & On-Site Dental Services
 106 East Due West Ave.
 Madison, TN 37115
 Office 615.865.1732 Fax 615.865.9223
 www.MarkThomassonDDS.com

Patient # _____

PATIENT INFORMATION RECORD

PATIENT INFO

DATE _____

Name _____ Birthdate ____/____/____ Soc. Sec. # ____ - ____ - ____
 Home Address _____ City _____ State _____ Zip _____
 Mailing Address (if different from above) _____ City _____ Zip _____
 Phone #: Hm _____ Wk _____ Ext _____ Cell _____
 Email Address _____ Occupation _____
 Employer Name & Address _____
 Please check appropriate box: Minor Single Married Separated Divorced Widowed
 Who may we thank for referring you? _____ Who is responsible for your account? _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal check VISA / Mastercard / Discover Office Finance Plans

SPOUSE / PARENT INFO

Name of (check which): Spouse Parent _____ Is this person a patient in our office? _____
 Home Address (if different from patient) _____ Hm Phone _____
 Wk Phone _____ Ext _____ Cell Phone _____ Email Address _____
 Soc. Sec. # ____ - ____ - ____ Birthdate ____/____/____ Occupation _____
 Employer Name & Address _____
 Person to Contact in Case of Emergency _____ Relationship _____ Phone #'s _____

DENTAL INSURANCE INFO

Do You Have Dental Insurance? Yes No

Primary Dental Ins. Carrier _____ ID # _____ Group # _____
 Policyholder's Name _____ Relationship to Patient _____
 Secondary Dental Ins. Carrier _____ ID # _____ Group # _____
 Policyholder's Name _____ Relationship to Patient _____

HEALTH HISTORY

Physician Name _____ Location _____

Phone Number _____ Date of Last Exam _____

Are you under medical treatment now? Yes No Why? _____

Are you taking any MEDICATION (including non-prescription): Yes No PLEASE LIST ALL:

Please list any recreational drugs you currently use and frequency: N/A

Have you ever taken Fen-Phen/Redux? Yes No

Alcohol Consumption: Yes No Amount: _____ Frequency: _____

Do you use tobacco? Yes No If yes, check which type: Cigarettes Smokeless

How much per day? _____

Do you have a prosthetic joint? Yes No If yes, where: _____

Have you ever had complications or prolonged bleeding following tooth extraction or any surgery? Yes No

Please explain _____

Are you allergic or had a reaction to: (check if yes)

- Local Anesthetics (ex. Novocaine)
- Penicillin
- Sulfa Drugs
- Barbiturates (sleeping pills)
- Metals (ex. Nickel, Mercury, etc.)
- Codeine or other narcotics
- Sedatives
- Iodine
- Aspirin
- Latex Rubber
- Other _____
- NO KNOWN ALLERGIES

Women Only: (check if yes)

Pregnant or think you may be? Number of weeks _____ Nursing?

Have you ever had or been treated for any of the following ? (check if yes)

- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Heart Surgery
- Heart Disease
- Heart Murmur
- Irregular Heart Beat
- Angina (chest pain)
- Cardiac Pacemaker
- Damaged heart valve / MVP
- Epilepsy / Convulsions
- Rheumatic Fever
- AIDS/HIV
- Asthma
- Seizures / Fainting
- Anemia
- Respiratory Problems
- Emphysema
- Arthritis
- Leukemia
- Diabetes
- Kidney Disease
- Thyroid
- Hepatitis / Jaundice
- Stomach Problems / Ulcers
- Liver Disease
- Cancer
- Radiation Therapy
- Stroke
- Allergies / Hay Fever
- Sinus Problems
- Tuberculosis
- Eye Disease / Glaucoma
- Recent Weight Loss
- Easily Winded
- Frequently Tired
- Drug / Alcohol Dependency
- Anxiety / Depression
- Migraines

DENTAL HISTORY

Previous Dentist _____ Location _____ Phone _____

Date of Last Visit _____ Reason _____

Please check the appropriate box:

YES NO

- Do you feel pain to any of your teeth?
- Do you have or have you had gum trouble or treatment (ex. Periodontal disease, Pyorrhea, etc.) ?
- Orthodontic Treatment? If yes, Previously OR Currently
- Have you ever worn a nightguard? Previously OR Currently
- Do you wear partials or dentures? If yes, date of placement _____
- Have you ever had any face or jaw injuries? If yes, explain _____
- Are you extremely nervous of dental procedures?
- Have you had any unpleasant dental experiences? If yes, explain _____

Please check any of the following which are of concern:

- | | | |
|---|--|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Popping / Clicking of Jaw | <input type="checkbox"/> Wisdom Teeth |
| <input type="checkbox"/> Sensitivity to Hot / Cold | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Loose Denture / Partial |
| <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Bad Bite / Crooked Teeth | <input type="checkbox"/> Excessive Decay |
| <input type="checkbox"/> Clenching or Grinding Teeth | <input type="checkbox"/> Lip / Mouth Ulcers | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Sensitivity when Chewing | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Mouth Odor |
| <input type="checkbox"/> Pain in/around Ears | <input type="checkbox"/> Brushing Habits | <input type="checkbox"/> Color of Teeth |
| <input type="checkbox"/> Lip / Cheek or Tongue Biting | <input type="checkbox"/> Flossing | <input type="checkbox"/> Overall Appearance of Teeth |

Any additional comments or concerns: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

PATIENT SIGNATURE (or parent/guardian if minor) X _____

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