Thodas & Tran
general dentistry

Date _____

PATIENT INFORMATION

Name _____ Cell phone _____

Preferred name _____ Home phone _____

Address _____ Email _____

City _____ Zip _____ Employer _____

Birthdate _____ Position/Profession _____

Whom may we thank for referring you? _____

IF PATIENT IS A DEPENDENT

Person responsible for account _____ Cell phone _____

Relationship to patient _____ Email _____

EMERGENCY CONTACT

Contact person _____ Cell phone _____

Relationship to patient _____ Home/Work phone _____

PRIMARY INSURANCE CARRIER

Name of insured _____

Birthdate _____

ID number _____

Insurance carrier name _____

Insurance carrier phone _____

Employer _____

Group number _____

SECONDARY INSURANCE CARRIER

Name of insured _____

Birthdate _____

ID number _____

Insurance carrier name _____

Insurance carrier phone _____

Employer _____

Group number _____

MEDICAL HISTORY

Are you in good health?	☐ Yes	☐ No, (explain)	
Any changes in your health within the last year?	☐ No	☐ Yes, (explain)	
Have you been hospitalized or had a serious illness in last three years?	☐ No	☐ Yes, (explain)	
Are you taking any drugs/medication?	☐ No	☐ Yes, (explain)	
Are you allergic to certain antibiotics?	☐ No	☐ Yes, (explain)	
Are you sensitive or allergic to any drugs?	☐ No	☐ Yes, (explain)	
Have you had any serious illness?	☐ No	☐ Yes, (explain)	

Check if you have the following prosthetic replacements ☐ Hip, date _____ ☐ Knee, date _____ ☐ Joint, date _____

Do you wear the following sleep appliances? ☐ CPAP ☐ Snore guard ☐ Night guard ☐ Other _____

Are you allergic to latex?	☐ No	☐ Yes
Are you allergic to any metals?	☐ No	☐ Yes
Have you ever had a bad reaction to a local anesthetic (Novocaine, Lidocaine)?	☐ No	☐ Yes
Have you taken or are taking Bisphosphonate medication for treatment of osteoporosis	☐ No	☐ Yes
Have you tested positive for COVID-19? If yes, what is your test date _____	☐ No	☐ Yes

Date of last physical exam _____

Physician's name _____

Phone _____

Indicate which of the following you have had or have at present

Heart failure	☐ No	☐ Yes	Drug addiction	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Heart disease or attack	☐ No	☐ Yes	Stroke	☐ No	☐ Yes	Hepatitis A or B	☐ No	☐ Yes
Angina pectoris	☐ No	☐ Yes	Kidney disease	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes
Congenital heart disease	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	AIDS / HIV	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	Ulcers	☐ No	☐ Yes	Cold sores/blisters	☐ No	☐ Yes
Mitral valve prolapse	☐ No	☐ Yes	Thyroid problems	☐ No	☐ Yes	Blood transfusion	☐ No	☐ Yes
Artificial heart valve	☐ No	☐ Yes	Cosmetic surgery	☐ No	☐ Yes	Hemophilia	☐ No	☐ Yes
Pacemaker	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
Heart surgery	☐ No	☐ Yes	Emphysema	☐ No	☐ Yes	Sickle cell disease	☐ No	☐ Yes
Arteriosclerosis	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Bruise easily	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Liver disease	☐ No	☐ Yes
Rheumatic fever	☐ No	☐ Yes	Hay fever	☐ No	☐ Yes	Yellow jaundice	☐ No	☐ Yes
Arthritis/Rheumatism	☐ No	☐ Yes	Hives	☐ No	☐ Yes	Epilepsy or seizures	☐ No	☐ Yes
Sleep apnea	☐ No	☐ Yes	Sinus trouble	☐ No	☐ Yes	Fainting or dizzy spells	☐ No	☐ Yes
Pain in jaw joints	☐ No	☐ Yes	Radiation therapy	☐ No	☐ Yes	Psychiatric treatment	☐ No	☐ Yes
Cortisone medicine	☐ No	☐ Yes	Chemotherapy	☐ No	☐ Yes	Eating disorder	☐ No	☐ Yes

FOR WOMEN ONLY

1. Pregnant? ☐ No ☐ Yes, month 1 2. Nursing? ☐ No ☐ Yes 3. Taking birth control? ☐ No ☐ Yes

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

CONSENT

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnostic of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (patient name) _____ and further authorizes and consent that the 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 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I 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 or Guardian signature _____ Date _____

Patient or Guardian name _____

Doctor signature _____ Date _____