Dr. Robert R. Thousand, III, D.D.S.

PLEASE FILL OUT COMPLETELY

PATIENT	REFERRING DENTIST:
NAME:	GENERAL DENTIST:
ADDRESS:	INCASE OF EMERGENCY CONTACT:
CITY: STATE: ZIP:	PHONE #:
HOME PHONE: CELL PHONE:	RELATIONSHIP TO PATIENT:
BUSINESS PHONE:	All fees are payable when service is rendered. Payment delayed beyond 30 days may incur
SOCIAL SECURITY #:	additional charges. Delinquent accounts are subject to finance charges and collection fees.
BIRTHDATE:	There is a fee for returned checks.
OCCUPATION:	DENTAL INSURANCE CO: GROUP #:
EMPLOYER:	EMPLOYEE NAME: BIRTHDAY:
BUSINESS ADDRESS:	RELATIONSHIP TO EMPLYEE: SELF ( ) SPOUSE ( ) CHILD ( )
CITY: STATE: ZIP	SOCIAL SECURITY #:

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any dental information necessary in order to process insurance claims and I authorize payment of dental benefits to Robert R. Thousand, III, D.D.S. for professional services rendered. I agree that I am responsible for all dental fees and that my insurance is filled as a courtesy to me. I am responsible for any outstanding insurance balance of over 60 days from date of service. In case of default of payment, I agree to pay any reasonable attorney and/or collection fees.

MEDICAL HISTORY

	YES	NO
Anemia……………………………….	☐	☐
Artificial Joint/Valve…………………	☐	☐
Asthma………………………………	☐	☐
Bleeding Tendency…………………	☐	☐
Cancer……………………………….	☐	☐
Cardiovascular Disease……………. (Heart Attack, Stroke, By-Pass)	☐	☐
Chemotherapy……………………….	☐	☐
Colitis…………………………………	☐	☐
Congenital Heart Disease………….	☐	☐
Convulsions/Seizures………………	☐	☐
Cortisone or Steroid Therapy……….	☐	☐
Diabetes/Hypoglycemia…………….	☐	☐

	YES	NO
Dizziness/Fainting………………….	☐	☐
Drug/Alcohol Addiction…………….	☐	☐
Frequent Swollen Ankles………….	☐	☐
Gastrointestinal Problems…………	☐	☐
HIV Positive…………………………	☐	☐
Heart Murmur/Mitral Valve Prolapse	☐	☐
Hepatitice (A or B or C)……………	☐	☐
Kidney Disease…………………….	☐	☐
Liver Disease……………………….	☐	☐
High Blood Pressure……………….	☐	☐
Lung-Disease……………………….	☐	☐
Pacemaker………………………….	☐	☐
Pregnant……………………………	☐	☐

	YES	NO
Low Blood Pressure…………………	☐	☐
Prosthetic Valve………………………	☐	☐
Psychiatric Treatment………………	☐	☐
Radiation Therapy……………………	☐	☐
Recent Illness……………………….	☐	☐
Rheumatic Fever…………………….	☐	☐
Sinus Trouble……………………….	☐	☐
Stomach Ulcers or Irritable Bowel Syndrome…………………….	☐	☐
Temporomandibular Joint Problems.	☐	☐
Thyroid Problems……………………	☐	☐
Tuberculosis…………………………	☐	☐
Ulceritive Colitis………………………	☐	☐

	YES	NO
Are you under the care of a physician for a current problem? …………………………………	☐	☐
Nature of treatment ____		
Have you been hospitalized within the past five years? …………………………………………	☐	☐
Reason ____		

Please specify any **allergic or adverse reactions** you may have ever had to any **anesthetics, latex, antibiotics, or other medications**:___________________________________

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	YES	NO
Are you required to take antibiotics prior to dental treament, due to a heart condition or an artificial joint replacement? …………………………………………………………………..	☐	☐
Have you ever taken **Fenfluramine** and **Dexfenfluramine** for weight control? …………..	☐	☐
Are you taking Birth Control Pills? ……………………………………………………………….	☐	☐

(If yes, be advised that if you take antibiotics, an alternate method of birth control must be used).

ALL OF THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

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Signature of Patient Date

I AM PRESENTLY TAKING:

- ☐ No Drugs
- ☐ Pain Medicine
- ☐ Aspirin
- ☐ Blood Thinner
- ☐ Antibiotics
- ☐ Heart Medicine
- ☐ Cortisone/ Steroids
- ☐ Blood Pressure Medicine
- ☐ List Medications ______________

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