

LEAWOOD COSMETIC & FAMILY DENTISTRY - KELLY K. THOMAS DDS

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION						
Patient's Last name:	First:	Middle Initial:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Preferred Name:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Email:		
Street address:				City:	State:	
ZIP Code:	Home phone no.: ()	Cell phone no.: ()		Social Security no.:		
Occupation:	Employer:			Employer phone no.: ()		
Person responsible for bill:						
Referred by:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Name of Primary Insurance:	Subscriber's name:	Subscriber's S.S. no.:	Birth date / /			
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:		
Occupation:	Employer:			Employer phone no.: ()		
Group no.:	Policy no.:					
Name of secondary insurance (if applicable):	Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /			
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:		
Occupation:	Employer:			Employer phone no.: ()		
Group no.:	Policy no.:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()

I, the undersigned, understand and agree there will be a late charge of \$10.00 per month of any past due account over thirty days. I also understand and agree that if I am in default of this agreement, my balance will be sent to a collections agency and I will be responsible for all costs incurred to collect my delinquent account. My increased balance will be calculated by dividing my current unpaid balance by (.65). In the event an attorney would be required, my unpaid balance would be divided by (.50).

Patient/Guardian signature

Date

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HEALTH HISTORY

NAME <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DATE:
MEDICAL PHYSICIAN:		MEDICAL PHYSICIAN'S PHONE #:	
DATE OF LAST DENTAL EXAM:		DATE OF LAST DENTAL X-RAYS:	
PERSONAL HEALTH HISTORY			
Allergies:	<input type="checkbox"/> Latex	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other:
	<input type="checkbox"/> Codeine	<input type="checkbox"/> Metal	
	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Local Anesthetics	
LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING ASPIRIN):			
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:			
<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Asthma/Breathing Problems	<input type="checkbox"/> Clenching	<input type="checkbox"/> Sensitive Teeth
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Jaw Popping/Clicking	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Jaw Ache	<input type="checkbox"/> Difficulty Chewing
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Limited Opening	<input type="checkbox"/> Trigeminal Neuralgia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Tingling/Numbness in Fingers
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Radiation/Chemotherapy	<input type="checkbox"/> Pain around Ears	<input type="checkbox"/> Bell's Palsy
<input type="checkbox"/> Stents	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Neck Ache	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Stroke	<input type="checkbox"/> Psychiatric/Psychological	<input type="checkbox"/> Shoulder Ache	<input type="checkbox"/> Habitual Biting the sides of Cheek
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Backache	<input type="checkbox"/> Habitual Biting sides of Tongue
<input type="checkbox"/> Artificial Joints/Pins/Plates	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Gums Bleed
<input type="checkbox"/> Transplant	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Ringing of Ears	<input type="checkbox"/> Other:
<input type="checkbox"/> Clotting Problems	<input type="checkbox"/> Grinding	<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Other:
Does floss catch between your teeth?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your breath concern you?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does food pack between your teeth?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any sores or spots in your mouth that have been present more than two weeks?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke or chew tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Trying to become pregnant?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking birth control?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you know of any reason you are required to take a pre-medication of an antibiotic prior to medical or dental treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Any disease/conditions not listed:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Anything we should know to better serve you:			

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____ Date: _____

LEAWOOD COSMETIC & FAMILY DENTISTRY
KELLY K. THOMAS DDS

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Leawood Cosmetic & Family Dentistry Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

If this Acknowledgement is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

FOR OFFICE STAFF USE ONLY:

An attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____