Katrice L. Thomas, D.M.D., P.C.

WELCOME TO OUR PRACTICE!

3845 Interstate Court, Suite 2 • Montgomery, Alabama 36109 • (334) 260-7757

PATIENT INFORMATION

NAME	NAME YOU PREFER	BIRTHDATE	AGE	HOME PHONE ( )

MAILING ADDRESS	CITY	STATE	ZIP	WORK PHONE ( )

EMPLOYER (OR SCHOOL)	BUSINESS ADDRESS	CITY	STATE	ZIP

FAX #	E-MAIL	CELL PHONE	S.S.#	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED	MALE FEMALE

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE	IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE? NAME / RELATIONSHIP

PERSON RESPONSIBLE FOR ACCOUNT

NAME	RELATIONSHIP TO PATIENT

DENTAL INSURANCE INFORMATION

	PRIMARY	SECONDARY
INS. COMPANY		
EMPLOYER NAME		
EMPLOYEE NAME		
SOCIAL SECURITY NO.		
CONTRACT NO.		
GROUP NUMBER		

FAMILY INFORMATION

	FATHER/HUSBAND	MOTHER/WIFE
NAME		
STREET ADDRESS		
CITY / STATE / ZIP		
HOME PHONE / WORK PHONE		
BIRTHDATE / SOCIAL SECURITY NO.		
EMPLOYER NAME		

NEAREST RELATIVE NOT LIVING WITH YOU (IN CASE OF EMERGENCY)

NAME / TELEPHONE	ADDRESS	CITY	STATE	ZIP

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

XI _____ DATE _____

☐ Adult Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

PATIENT REGISTRATION

DENTAL HISTORY

Do you have a specific dental problem? Des e _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Would you describe your present dental health as good? Comments _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do your gums ever bleed? Discuss _____ YES NO
Do you brush and floss on a routine basis? Discuss _____ YES NO
Do you feel nervous about having dental treatment? _____ YES NO
Have you ever had a bad experience in a dental office? Describe _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Do you like your smile? Why _____ YES NO
Name of previous dentist (optional) _____ YES NO
Do you ever brux or grind your teeth? Discuss _____ YES NO
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Discuss _____ YES NO

MEDICAL HISTORY

Medical doctor's name_____Address_____Phone_____
Are you under a doctor's care now? Why? _____ YES NO
Are you taking any medications, pills, or drugs? What? _____ YES NO
Are you allergic to any medications or substance? What? _____ YES NO
Do you smoke or use tobacco products? _____ YES NO
Are you pregnant? ❑ Yes, what month?_____ ❑No Are you nursing? ❑Yes ❑No Are you taking birth control pills ❑Yes ❑No
Have you every taken Redux or Fen-Phen _____ YES NO

Please CIRCLE if you have had any of the following:

Heart Trouble	Heart Pacemaker	Kidney Trouble	Yellow Jaundice	Alzheimers Disease
High Blood Pressure	Heart Surgery	Ulcers	Recent Weight Loss	Hypoglycemia
Low Blood Pressure	Blood Disease	Allergies	Cancer/Tumor	Psychiatric Care
Angina Pectoris	Anemia	Scarlet Fever	Thyroid Disease	Drug Addiction
Arteriosclerosis	Chest Pain	Asthma	Parathyroid Disease	Blood Transfusion
Mitral Valve Prolapse	Shortness of Breath	Hay Fever	X-ray or Cobalt Tmt.	Hemophilia
Cosmetic Surgery	Swelling of Feet/Ankles/	Sinus Trouble	Chemotherapy/Radiation	Venereal Disease
A.I.D.S.	Hands	Emphysema	Arthritis/Gout	Cold Sores
H.I.V. Positive	Fainting or Dizziness	Frequent Cough	Rheumatism	Fever Blisters
Developmentally Disabled	Stroke	Lung Disease	Pain in Jaw Joints	Herpes
Rheumatic Fever	Diabetes	Tuberculosis	Cortisone Medicine	Bruise Easily
Congenital Heart Disease	Excessive Thirst	Liver Disease	Glaucoma	Sickle Cell Anemia
Artificial Heart Valve	Artificial Joints/Hips	Hepatitis A (infec.)	Epilepsy or Seizures	Special Diet
Heart Murmur		Hepatitis B (serum)	Nervousness	Recent surgery _____ year

Have you ever had any other serious illness not circled above?_____ ❑YES ❑NO
Please describe in detail _____

COMMENTS: _____

CONSENT

1. 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.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court cost if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

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.

Signature (Parent or Guardian)_____

Date_____ Reviewed by Dr.:_____

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	None ❑ _____	DR._____
_____	_____	None ❑ _____	DR._____

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FAMILY DENTISTRY

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FINANCIAL POLICY

1. We accept cash, most major credit cards, debit cards, and checks with proper ID. All returned checks will be charged a $30.00 fee. Payment is expected at the time of service.

2. I understand and agree that I am responsible for all charges on my account. Insurance is filed, as a courtesy, by this office. If insurance does not pay within 45 days I am responsible for the balance. Our office will gladly reimburse you when we have received the insurance payment.

3. I also understand that this office cannot make an exact estimate of the insurance benefits to be paid since it does not have access to all insurance company records and fee schedules. I am aware that after the insurance company pays all dental claims there could be a balance that must be paid by me.

4. There will be a $40.00 fee for all cancellations and broken appointments, if you do not give at least 24 hours notice. We reserve the right to dismiss a patient from our practice after three consecutive broken appointments, habitually cancelled and rescheduled appointments, uncooperative patients and non-compliance of recommended treatment. We strive to provide quality dentistry for all patients and broken and rescheduled appointments hinder our efforts and desires to render these services.

5. There will be a 1.5% finance charge added to all accounts over 30 days past due regardless of whether the balance is outstanding insurance claims or co-payments due by the patients. To avoid this charge, you may pay your bill in full and we will gladly reimburse you upon receiving your insurance payment.

6. I AM AWARE AND UNDERSTAND THAT SHOULD MY ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR ALL ATTORNEY'S FEES AND COLLECTION EXPENSES INCURRED.

_____ _____

Patient's Signature Today's Date