JONATHAN THOMAS DDS
Smiles with Aloha

CONFIDENTIAL PATIENT INFORMATION

Aloha

Patient#_____

Social Security#_____

Date_____

PATIENT INFORMATION

Name_____DOB_____Social Security#_____

Address_____City_____State_____Zip_____

Email_____Mobile#_____Home#_____

Employer_____Work#_____Check Appropriate Box: SINGLE ☐ MARRIED ☐

RESPONSIBLE PARTY

Name_____DOB_____Social Security#_____

Address_____City_____State_____Zip_____

Email_____Mobile#_____Home#_____

Employer_____Work#_____ Address_____

HOW DID YOU LEARN ABOUT US?

FRIEND ◯ YELP ◯ GOOGLE ◯

WHOM MAY WE THANK FOR REFERRING YOU?

Is This Person Currently A Patient In Our Office? YES ☐ NO ☐

PAYMENT OPTIONS

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.

PAYMENT IN FULL IS DUE AT EACH APPOINTMENT

PLEASE MARK THE PAYMENT OPTION YOU PREFER

CHECK ◯ CASH ◯ CARE CREDIT ◯ MASTERCARD ◯ VISA ◯ I WISH TO DISCUSS PAYMENT POLICY ◯

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE KNOWLEDGE 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 RECORDS TO THIRD PARTY PAYORS. 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.

☒ _____DATE:_____

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PATIENT MEDICAL HISTORY

Aloha

Patient#_____

Social Security#_____

Date_____

PRIMARY CARE PHYSICIAN

PHYSICIAN_____ OFFICE PHONE_____ DATE OF LAST EXAM_____

ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?_____

ARE YOU CURRENTLY TAKING ANY MEDICATION (S) INCLUDING NON-PRESCRIPTION MEDICINE?_____

IF YOU ANSWERED YES, WHAT MEDICATIONS ARE YOU TAKING?_____

WOMEN ONLY: ARE YOU PREGNANT?_____ ARE YOU NURSING?_____ ARE YOU TAKING CONTRACEPTIVES?_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

1. HIGH BLOOD PRESSURE	◯ YES	◯ NO	9. LEUKEMIA	◯ YES	◯ NO	17. HEART MURMUR	◯ YES	◯ NO	25. ULCERS	◯ YES	◯ NO
2. HEART ATTACK	◯ YES	◯ NO	10. DIABETES	◯ YES	◯ NO	18. ANGINA	◯ YES	◯ NO	26. OSTEOPOROSIS	◯ YES	◯ NO
3. RHEUMATIC FEVER	◯ YES	◯ NO	11. KIDNEY DISEASE	◯ YES	◯ NO	19. FREQUENTLY TIRED	◯ YES	◯ NO	27. STROKE	◯ YES	◯ NO
4. SWOLLEN ANKLES	◯ YES	◯ NO	12. AIDS/HIV	◯ YES	◯ NO	20. EMPHYSEMA	◯ YES	◯ NO	28. HAY FEVER/ALLERGIES	◯ YES	◯ NO
5. FAINTING/SEIZURES	◯ YES	◯ NO	13. THYROID PROBLEM	◯ YES	◯ NO	21. CANCER	◯ YES	◯ NO	29. RADIATION THERAPY	◯ YES	◯ NO
6. ASTHMA	◯ YES	◯ NO	14. ACID REFULX	◯ YES	◯ NO	22. ARTHRITIS	◯ YES	◯ NO	30. LIVER DISEASE	◯ YES	◯ NO
7. LOW BLOOD PRESSURE	◯ YES	◯ NO	15. HEART DISEASE	◯ YES	◯ NO	23. JOINT REPLACEMENT	◯ YES	◯ NO	31. TUBERCULOSIS	◯ YES	◯ NO
8. EPILEPSY/CONVULSIONS	◯ YES	◯ NO	16. PACEMAKER	◯ YES	◯ NO	24. HEPATITIS/JAUNDICE	◯ YES	◯ NO	32. HEART TROUBLE	◯ YES	◯ NO

1. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS WITHIN THE LAST FIVE YEARS?	◯ YES	◯ NO
2. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	◯ YES	◯ NO
3. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISOPHONATES?	◯ YES	◯ NO
4. DO YOU USE TOBACCO?	◯ YES	◯ NO
5. DO YOU USE CONTROLLED SUBSTANCES?	◯ YES	◯ NO
6. ARE YOU WEARING CONTACT LENSES/	◯ YES	◯ NO
7. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS?	◯ YES	◯ NO

ALLERGIES

1. LOCAL ANESTHETICS	◯ YES	◯ NO
2. PENICILLIN/ANTIBIOTICS	◯ YES	◯ NO
3. SULFA DRUGS	◯ YES	◯ NO
4. BARBITURATES	◯ YES	◯ NO
5. IODINE	◯ YES	◯ NO
6. ASPRIN	◯ YES	◯ NO
7. ANY METALS	◯ YES	◯ NO
8. LATEX RUBBER	◯ YES	◯ NO
9. OTHER:_____		

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X _____ DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Jonathan M. Thomas, DDS, Inc. The statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and the duties and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Jonathan M. Thomas, DDS, Inc. reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable discloses described in the Statement of Privacy Practices, **I hereby specifically authorize disclosure of my Protected Healthcare to the person(s) identified below**. I understand that the default answer is NO. Without indicting YES in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.

I hereby specifically authorize disclosure of my Protected Healthcare to the person(s) identified below.

SPOUSE ◯ CHILDREN ◯ PARENTS ◯ GRANDCHILDREN ◯

PRINT NAME: SIGNATURE: DATE:

PATIENT REPRESENTATIVE NAME: SIGNATURE:

PHONE NUMBER: DATE:

OFFICE USE ONLY

ACKNOWLEDGMENT NOT OBTAINED

REASON FOR NOT OBTAINING PATIENT SIGNATURE

- WANTED TO CONSULT ANOTHER PERSON BEFORE SIGNING ◯
- NEEDED MORE TIME TO REVIEW STATEMENT ◯
- PHYSICALLY UNABLE TO SIGN ◯
- NO REASON OFFERED ◯
- OTHER: ◯

ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES PROVIDED PRIOR TO TREATMENT?

◯ YES ◯ NO

DATE STATEMENT PROVIDED:_____

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PATIENT DENTAL HISTORY

WHAT PROMPTED YOU TO CONTACT OUR OFFICE FOR AN APPOINTMENT?_____

HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH DENTISTRY? ◯ YES ◯ NO

DOES DENTAL TREATMENT MAKE YOU NERVOUS? ◯ YES ◯ NO

DO YOU USE THE FOLLOWING

TOOTHBRUSH ◯ YES ◯ NO HOW OFTEN?_____

DENTAL FLOSS ◯ YES ◯ NO HOW OFTEN?_____

OTHER ORAL HYGIENE DEVICE ◯ YES ◯ NO WHAT & HOW OFTEN?_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING

LOOSE TEETH ◯ YES ◯ NO HOW LONG?_____

BAD BREATH ◯ YES ◯ NO HOW LONG?_____

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	◯ YES	◯ NO	9. HAVE YOU EVER HAD DIFFICULTY CHEWING	◯ YES	◯ NO
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	◯ YES	◯ NO	10. DO YOU HAVE FREQUENT HEADACHES	◯ YES	◯ NO
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	◯ YES	◯ NO	11. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	◯ YES	◯ NO
4. DO YOU FEEL PAIN ON OR AROUND YOUR TEETH	◯ YES	◯ NO	12. HAVE YOU HAD PROLONGED BLEEDING FOLLOWING EXTRACTION	◯ YES	◯ NO
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	◯ YES	◯ NO	13. HAVE YOU EVER HAD ORTHODONTIC TREATMENT	◯ YES	◯ NO
6. HAVE YOU EVER HAD ANY HEAD, NECK OR JAW INJURIES	◯ YES	◯ NO	14. DO YOU WEAR DENTURES OR PARTIALS	◯ YES	◯ NO
7. HAVE YOU EVER HAD CLICKING IN YOUR JAW	◯ YES	◯ NO	15. DO YOU HAVE EAR OR SIDE OF FACE PAIN	◯ YES	◯ NO
8. HAVE YOU EVER HAD DIFFICULTY OPENING OR CLOSING YOUR JAW	◯ YES	◯ NO	16. DO YOU HAVE JOINT PAIN	◯ YES	◯ NO

1. ON A SCALE OF 1-10 (1 BEING TERRIBLE AND 10 BEING PERFECT) HOW HEALTHY DO YOU THINK YOUR MOUTH IS?_____

2. ON A SCALE OF 1-10 (1 BEING TERRIBLE AND 10 BEING PERFECT) HOW HEALTHY WOULD YOU LIKE YOUR MOUTH TO BE?_____

3. ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?

IF YOU ANSWERED NO AND YOU COULD INSTANTLY CHANGE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH, WHAT WOULD YOU CHANGE?

_____

4. WHAT ARE SOME QUESTIONS ABOUT DENTISTRY AND YOUR ORAL HEALTH THAT YOU HAVE NEVER HAD ADEQUATELY ANSWERED?

_____

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