

Ralph W. Thacker DMD

222 Main Street, Livermore, KY 42352

PO Box 490

Phone: 270-278-2385 Fax: 270-278-5111

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

In Case of Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom can we thank for referring you to us? _____

Account Information

☐ Person responsible for this account is the same as above

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Birthday: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

☐ Additional Insurance

Last Name: _____ First Name: _____ Middle Initial: _____ Mr | Dr | Mrs | Miss | Ms

Mailing Address: (Street, City, State, Zip) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Do you want Email reminders? ☐ Yes ☐ No

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Employer Address: (Street, City, State, Zip) _____

Insurance Company: _____ ID Number: _____ Group Number: _____

Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _____ Date: _____

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Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Please list any medications, pills, or drugs you are taking: _____

Women: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Other Serious Illness
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A, B, or C	<input type="checkbox"/> Rheumatic Fever	Please Explain: _____
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Headaches	<input type="checkbox"/> Rheumatism	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shingles	_____
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Sickle Cell Disease	_____
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sinus Trouble	_____
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Spina Bifida	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach Disease	_____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Intestinal Disease	_____
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Swelling of Limbs	_____
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mitral Valve Problems	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tumors or Growths	_____
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Venereal Disease	_____
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Yellow Jaundice	_____

Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or emissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** _____ Date: _____