# THOMPSON FAMILY DENTAL

**2518 W. 15th Ave * Emporia, KS * (620) 343-8000**

Name _____ Male ___ Female___
Address_____City _____ State ____ ZIP Code _____
Home Phone _____ Cell _____ Work _____
Birthdate _____ Age____ SSN _____ Married ___ Single ___ Divorced___
Email: _____@_____._____
Patient Employer/School _____ Occupation/Grade_____
Whom may we thank for referring you? _____

## MEDICAL HISTORY

Physician's Name _____ Pharmacy _____
Is patient currently taking any medications ? If yes, list all: _____
_____

Please mark all that apply:

___AIDS/HIV ___Diabetes ___High blood pressure ___Tuberculosis ___Anemia ___Epilepsy
___Arthritis ___Hepatitis ___Radiation treatment ___Pacemaker ___Asthma ___Heart Murrmur
___Heart Disease ___Nervous/Mental Disorder ___Bisphosphonate treatment
___Artificial Joints: _____
___Cancer: _____
___Other: _____

Women: Are you pregnant? If so, how many weeks? Due date? _____
Is Patient allergic to any of the following?:
___Penicillin ___Codeine ___Latex ___Aspirin ___Sulfa ___Other:_____
Emergency contact: _____ Phone _____

## AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

**Signature** _____ **Date** _____

**PAYMENT IS DUE IN FULL AT TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED. WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED OR BROKEN WITHOUT 24 HOURS NOTICE.**