



# Amanda L. Thompson, D.M.D., P.C.

COSMETIC & FAMILY DENTISTRY

1932 Laurel Road, Suite 1A • Vestavia Hills, AL 35216  
Phone: 205-823-6776 • Fax: 205-823-6076 • www.AmandaThompsonDMD.com

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F  S

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Hay Fever               | <input type="checkbox"/> Radiation Treatment  |
| <b>Drug Allergies</b>                       | <input type="checkbox"/> Head Injuries           | <input type="checkbox"/> Respiratory Problems |
| _____                                       | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> <b>Heart Murmur/MVP</b> | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Arthritis          | <b>Premed yes/no</b>                             | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Tumors               |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Mental Disorders        | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Nervous Disorders       | <input type="checkbox"/> Codeine Allergy      |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Penicillin Allergy   |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> <b>Pregnancy</b>        |   |
| <input type="checkbox"/> Glaucoma           | <b>due date</b> _____                            |   |
| <input type="checkbox"/> Growths            |  |   |

**List all medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever taken the diet drugs Fenfluramine and or Dexfenfluramine  
**Yes/No**

IF **Yes** have you had an echocardiogram  
**Yes/NO**

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice? \_\_\_\_\_

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

### Consent for Services

Payment is due as services are rendered. Patients are responsible for the estimated out-of-pocket portion of their treatment as treatment is rendered. This includes yearly deductibles and co-pays. If we do not receive payment from your insurance company within 45 days of service, you will be responsible for the balance.

Our office uses tooth colored restorations only. Insurance companies will only pay their usual & customary fee for amalgam (silver) fillings, therefore, the patient is responsible for the difference in the amount paid by insurance and Dr. Thompson's fees. This balance is due at the time of service.

I authorize the use of this signature on all insurance submissions. I understand that I am responsible for all charges whether or not paid by insurance as well as any collection fees, attorney fees, and court costs accrued during collection of fees.

I authorize the dentist to release all information necessary to secure payment of benefits and to release records and/or radiographs if needed either by an insurance company or another dentist. A \$25.00 per hour broken appointment fee is subject without a 24 hour notice.

I have read the above conditions of treatment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_