5935US27 North, Suite 103|Sebring,FL 33870
Phone: (863) 382-0888|Fax: (863) 382-2888
WWW.drtinathomas.com

Name____ Date__________________________________

First Middle Last

Address______________________________ City______________________ State_____ Zip_______________

Cell # _____________________ Home Phone ________________Soc. Security # ______________ Birthday_____________

Email____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Widowed

Whom may we thank you for referring you?____

Person to contact in case of an emergency/phone number _____________________________________

Driver's License #___________________________________

Medical history

Physician's Name______________________ Date of last visit_____________________ Reason_______________________

Place a mark on "Yes or "No" to indicate if you have has an of the following

AIDS/HIV	Yes No	Fainting/Dizziness	Yes No	Scarlet Fever	Yes No
Anemia	Yes No	Glaucoma	Yes No	Shortness of Breath	Yes No
Arthritis,Rheumatic	Yes No	Headaches	Yes No	Sinus Toruble	Yes No
Artificial Heart Valve	Yes No	Hepatitis___	Yes No	Skin Rash	Yes No
Asthma	Yes No	Herpes	Yes No	Stroke	Yes No
Back Problems	Yes No	High Blood Pressure	Yes No	Swollen Neck Glands	Yes No
Bleeding Abnormally	Yes No	Jaundice	Yes No	Thyroid Problems	Yes No
Blood Disease	Yes No	Jaw Pain	Yes No	Tuberculosis	Yes No
Cancer	Yes No	Kidney Disease	Yes No	Tumor	Yes No
Chemical Dependency	Yes No	Liver Disease	Yes No	Ulcer	Yes No
Circulatory Problems	Yes No	Low Blood Pressure	Yes No	Venereal Disease	Yes No
Congenital Heart Lesion	Yes No	Mitral Valvue Prolapse	Yes No	Weight Loss- Explain	Yes No
Cortisone Treatment	Yes No	Nervous Problem	Yes No	For Women:	
Cough, Persistent/Bloody	Yes No	Pacemaker	Yes No	Are you nursing?	Yes No
Diabetes	Yes No	Psychiatric Care	Yes No	Take BCP?	Yes No
Drug use	Yes No	Radiation Treatment	Yes No	Are you pregnant?	Yes No
Emphysema	Yes No	Respiratory Disease	Yes No	Due Date:______________	
Epilepsy	Yes No	Rheumatic Fever	Yes No	Allergies:________________________________	

Please list any other conditions not listed:____

Medications: List the medications you are currently taking, doseage, and reason:

____

Hospitalization:____

Authorization:

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge. I also acknowledge full responsibility for the paymnent of such services and agree to pay in full at the time of service. I acknowledge this is my responsibility and not an insurance company to pay for all or any services. Any outstanding balance after 30 days may incur a financial charge.

X____ **Date**_________________________

Patient, Parent or Guardian (must be 18 or older)

Notice of Privacy Practices

I have been offered a copy of Tina M. Thomas, DMD, PA Privacy Policies.

X____ **Date**_________________________

Insurance Information

By signing below, I, the subscriber (or my dependent), verify insurance coverage and release all benefits, if any, otherwise payable to me for services rendered. I hereby authorize the release of necessary information to secure payment benefits. I accept responsibility for all accounts to be paid in full 60 days from the date of service regardless of insurance coverage.

X____ **Date**_________________________