TMC
TRUMAN MEDICAL CENTER
Lakewood

| Better. For Everyone.

Patient Identification Label

PATIENT INFORMATION

Please Print ***CONFIDENTIAL***

Date _____

Patient's First Name_____ **Last Name** _____ **MI** ____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____Ext _____

☐ I would like to receive confirmation/cancellation calls at work number provided

Cell phone(s) _____ Pager _____

Birth Date _____ Social Security_____ Driver's License _____

Sex ☐M ☐F Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

E-mail _____☐ I would like to receive correspondences via e-mail

Patient's Employment Status ☐Full Time ☐Part Time ☐Retired

Patient's Employer _____Phone Number_____

Business Address_____

City_____ State _____ Zip_____

Guardian's Name (Person responsible for payment for services) _____

Guardian's address same or _____City/State/Zip_____

Guardian's Social Security Number _____DOB _____

Guardian's Employer _____ Work phone_____

Person to contact in case of an emergency or if we are unable to reach you at your contact numbers:

Name _____ Phone number(s) _____

MISSED APPOINTMENT POLICY

We will make every attempt to make your appointments in a timely manner, and ask that you honor your commitment to keep your appointments. Appointments not cancelled within 24 hours of scheduled visit, are considered "missed appointments". Checking in for your appointment after your actual appointment time is also considered a missed appointment. Our clinic policy prohibits reappointment of patients after three (3) missed appointments occurring within a six (6) month period of time.

0214

_____ I have read and understand this Missed Appointment Policy.
Initials

RESPONSIBLE PARTY/POLICY HOLDER INFORMATION

Do you have family members on the same policy who are established patients in our practice?

__yes __no

If you checked yes, please list all family members who are currently patients in our practice

_____ _____

_____ _____

Primary Insurance Information

Name of insured/guarantor/subscriber (as printed on insurance card)

_____

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security Number_____ Insured Birth Date _____

Policy number/Subscriber ID _____

Group number _____Medicaid number_____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Phone number _____

Secondary Insurance Information

Name of insured/guarantor/subscriber (as printed on insurance card)_____

Relationship to Patient ☐Self ☐Spouse ☐Child ☐Other

Insured Social Security _____ Insured Birth Date _____

Policy Number/Subscriber ID _____

Group number _____ Medicaid number _____

Employer _____ Insurance Company _____

Address _____ Address _____

Address 2 _____ Address 2 _____

City, State, Zip _____ City, State, Zip _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that this is a fee-for service clinic and that my 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. ***Please note TMC Dental Care does not provide discounts based on income.***

X_____ _____

Signature of patient or parent/legal guardian **Date**

Updated 2016 Medical History(Copy)

Patient Name: Birth Date: Date Created:

Disclaimer

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

PLEASE CHECK APPROPRIATE ANSWER:

Is your general health good?	○ Yes ○ No	
Has there been a change in your health within the last year?	○ Yes ○ No	If yes
Have you been hospitalized or had a serious illness in the last three years?	○ Yes ○ No	If yes
Are you being treated by a physician now? For	○ Yes ○ No	If yes
Have you had any problems with prior dental	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you in pain now?	○ Yes ○ No	

WOMEN ONLY:

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

ARE YO ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Food
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes	
Do you use tobacco in any form?	☐	If yes	
Other?	○ Yes ○ No		

CURRENT HEALTH:

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Seizures	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Suicidal thoughts	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Yellow Jaundice	○ Yes ○ No						

Have you ever had any serious illness not listed	○ Yes ○ No	If yes	
PLEASE LIST ANY MEDICATIONS OR COMMENTS	☐		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____