THOMASSON DENTAL **(615)865-1732**

PATIENT INFORMATION

PATIENT INFO

Date: ________________

Name____ Birth Date _____/_____/_____ Soc. Sec. # ________-________-________

Home Address ____ City_______________________ State_______ Zip _______________

Mailing Address (if different from above)__________________________________ City_________ State _______Zip ________________

Phone #: Hm ______________________________ Wk ____________________________ Cell __________________________________

Email Address ____ Drivers License # _________________________________

Employer Name ____ Occupation __________________________________

Please check appropriate box: Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Who may we thank for referring you? _________________________ Who is responsible for your account? _________________________

We offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment.

Cash ☐ Personal check ☐ VISA / MasterCard / Discover ☐ Care Credit ☐

SPOUSE / PARENT INFO

Name of: Spouse ☐ / Parent ☐ (check one) ____________________________ Is this person a patient in our office? ___________

Home Address (if different from patient's) ____

Phone #: Hm ______________________________ Wk ____________________________ Cell _________________________________

Soc. Sec. # _______-________-________ Birth date ______/______/______ Email Address _________________________________

Employer Name____ Occupation____

Person to Contact in Case of Emergency ____________________ Relationship ______________ Phone #'s _______________________

DENTAL INSURANCE INFO

Do You Have Dental Insurance? Yes ☐ No ☐

Primary Dental Ins. Company Name ____ Group # _________________________

Policyholder's Name (person that carries the ins) ____________________________________ Relationship to Patient ______________

Policyholder's Info: Birth date ______/_______/_______ Soc.Sec. and/or ID # ____

Is this insurance with an Employer or Self-Insured Plan ? Employer ☐ if so/ name: ___________________________ Self-Insured ☐

Do you have Secondary Dental Insurance ? Yes ☐ No ☐ If so, please repeat above information below.

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DENTAL HISTORY

Do you wear a removable dental prosthesis (dentures, partial dentures, retainers)? Yes ☐ No ☐ _________________________

Have you ever been diagnosed with periodontal disease? Yes ☐ No ☐

Have you ever had any problem getting numb or had a reaction to local anesthetic? Yes ☐ No ☐

Have you ever had any serious problems associated with previous dental treatments? Yes ☐ No ☐

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