Dr. Martin Thompson D.D.S.
3026 S. Durango Dr. Suite 100
Las Vegas, NV 89117
(702) 363-1500

(Confidential for our files)

PERSONAL INFORMATION

Patient Name ______________________ Spouse ______________________
Patient SS# ______________________ Spouse SS# ______________________
Patient birth date ______________________ Spouse birth date ______________________
Person responsible for account ______________________
Address ______________________ Home phone ______________________
State __________ Zip Code __________ Work phone ______________________
Referred by ______________________ Cell Phone __________ Pager __________

EMPLOYER AND INSURANCE INFORMATION

PRIMARY DENTAL COVERAGE

Employee ______________________
Employer ______________________
Insurance Co. ______________________
Insurance Co. phone ______________________
Address ______________________
State __________ Zip Code __________

SECONDARY DENTAL COVERAGE

Employee ______________________
Employer ______________________
Insurance Co. ______________________
Insurance Co. phone ______________________
Address ______________________
State __________ Zip __________

HEALTH HISTORY (PLEASE INDICATE)

HEART	YES	NO
Mitral valve prolapse	___	___
Rheumatic fever	___	___
Heart Murmur	___	___
Heart attack (date________)	___	___
High blood pressure	___	___
Low blood pressure	___	___
Angina	___	___
Congenital heart disease	___	___
Artificial valves	___	___
Pacemaker	___	___
Heart surgery (date________)	___	___
DIGESTIVE SYSTEM		
Hepatitis	___	___
Jaundice	___	___
Ulcer	___	___
RESPIRATORY		
Tuberculosis	___	___
Emphysema	___	___
Asthma	___	___
Smoker ?	___	___
Other : ______________________		

ENDOCORINE	YES	NO
Diabetes	___	___
Thyroid condition	___	___
Steroid Therapy	___	___
URINARY/REPRODUCTIVE		
Kidney disease	___	___
Venereal disease	___	___
Syphilis	___	___
BONE		
Arthritis		
Artificial joints	___	___
Pins/Plates	___	___
Osteoporosis	___	___
TMJ	___	___
BLOOD		
Bleeding tendency	___	___
Anemia	___	___
Bruise easily	___	___
Transfusion	___	___
Sickle cell anemia	___	___
Hemophilia	___	___
HIV positive	___	___
Other : ______________________		

PLEASE TURN OVER

HEALTH HISTORY (CONTINUED)

NERVOUS SYSTEM	YES	NO
Stroke	____	____
Epilepsy	____	____
Numbness	____	____
Dizziness/fainting	____	____
Psychiatric treatment	____	____
Nervous disorders	____	____

GENERAL	YES	NO
Cancer	____	____
Chemotherapy	____	____
Radiation therapy		
Drug allergies		

NOSE	YES	NO
Frequent nose bleeds	____	____
Sinus problems	____	____
Throat		
Soreness/hoarseness	____	____
Cancer or tumor?	____	____
EARS		
Loss of hearing	____	____
Ringing in your ear	____	____

____

WOMEN ONLY		
Pregnant ? (months __________)	____	____
Post menopausal	____	____
Birth control pills	____	____
Hysterectomy (date______)	____	____

My doctor is ______________________________ Phone # ________________

Taking medications No_____ Yes_____ If yes, ______________________________

Allergic to medications: ______________________________

General health comments: ______________________________

Medical history updated on: ______________________________

GENERAL INFORMATION

What is your main concern with your teeth and mouth ? ______________________________

Have you ever considered cosmetic dentistry ? ______________________________

Have you ever been concerned about your breath ? ______________________________

Do you ever get a bad taste in your mouth______________ What kind? Blood_____ Iron_____ Other_____

Are you interested in improving your breath ? ______________________________

Are you currently using anything for breath control ? ______________________________

Prior unpleasant dental treatment or experience ? ______________________________

CONSENT FOR TREATMENT: I hereby give authorization to the dentist in charge of the care of this patient whose name appears on this form to administer any treatment, such as anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

SIGNED ______________________________ **DATE** ________________

UNLESS OTHER ARRANGEMENTS ARE MADE, I AGREE TO PAY ALL SERVICES AT THE TIME SUCH SERVICES ARE RENDERED. IF COLLECTION SERVICES ARE REQUIRED, I FURTHER AGREE TO PAY ALL LEGAL FEES AND COSTS INCURRED IN COLLECTION. FOR THOSE WITH INSURANCE, I REALIZE THAT DR. THOMPSON IS NOT A DENTAL INSURANCE PROVIDER, MY INSURANCE IS MY RESPONSIBILITY.

SIGNED ______________________________ **DATE** ________________

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DENTAL INSURANCE

As a *courtesy to you*, we will submit your claim to your insurance company, but please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company.
   We are not a party to that contract. *We work 100% for you, the patient.*

2. This office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. *You are responsible for the payment of your account.*

3. Your co-payment is an ***estimate*** of the amount you are required to pay and is due at the time of service. The extent of your co-pays and benefits, of course, will be determined by the type of insurance coverage you or your employer has purchased. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Please do not expect your insurance to cover everything.

We emphasize that, as a dental care provider, *our relationship is with you, not your insurance company*.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.
If you have any questions or concerns please feel free to contact our office staff. *We are here to help you.*

I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE REGARDING MY DENTAL INSURANCE.

Signed________________________________ **Date**____________

MARTIN THOMPSON D.D.S.
3026 S. DURANGO DR, SUITE 100
LAS VEGAS, NV 89117
(702)363-1500

THE FOLLOWING OUTLINES OUR BILLING POLICIES

Dental Insurance is a nice benefit and may pay different percentage amounts for each specific procedure.
Filing your private dental insurance form is a ***courtesy*** that we provide for our patients. **The ultimate responsibility for the patient's bill is the account holder.** Dr. Thompson is not a provider for any dental plan.

All new patients to our office must provide a copy of your driver's license, dental insurance card or a completed dental claim form.

It is the patient's responsibility to know if their insurance has a co-payment and an annual deductible. **Co-payments must be paid at each visit.**

We will be happy to bill your insurance for the ***estimated*** portion quoted by your dental plan, **however if the insurance does not pay within 90 days from the date of service, you will be responsible for the bill.**

CANCELLATION POLICY

We schedule appointments in an effort to minimize patient waiting. In order to keep scheduling efficiently, we ask that patients notify our office 72 hours before a scheduled appointment needs to be changed. This allows us an opportunity to accommodate another patient. **Cancellations with less than 24 hours notice will be subject to a $75 charge.** **Those patients who miss three appointments without proper notice will be dismissed from our practice.**

I____have read and
(Patient's signature)
Understand the policies above.

Date____________________ Witness initial____________