



Dental Medical History Form

Please complete all sections. This information is confidential and essential for providing safe, effective dental care.

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____

Gender: Female Male Non-binary Prefer not to say

Address: _____

City / State / ZIP: _____

Phone: _____ Cell Home Work

Email: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Dental Health Concerns

Do you have any concerns about your dental health?

Are you experiencing any pain or discomfort? No Yes — Please describe:

Dental History

Date of Last Dental Visit: _____ Reason: _____

Daily Habits

Brush daily Floss regularly Use mouth rinse

Dental Conditions (check all that apply)

Gum disease / periodontal treatment

Bleeding gums

Tooth sensitivity

Jaw pain / clicking (TMJ)

Grinding or clenching

Orthodontic treatment

Dental implants

Dentures or partials



Medical History

Primary Care Physician: _____ Phone: _____

Are you currently under medical care? No Yes — Please explain:

Have you had any surgeries? Type and date:

Medical Conditions (check all that apply)

High blood pressure

Heart disease

Heart murmur

Stroke

Diabetes

Asthma

COPD

Sleep apnea

Bleeding disorder

Joint replacement

Type of joint / year replaced: _____

Has your doctor instructed you to take antibiotic premedication for life? No Yes

Medications & Allergies

List all current medications (including supplements):

Do you use tobacco or marijuana? No Yes

Are you allergic to any medications or substances?

Latex

Penicillin

Local anesthetics

Other: _____

Women's Health (if applicable)

Pregnant

Nursing

Trying to become pregnant

Not applicable



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Additional Questions

Is there anything you would like to change about your smile?

Are you interested in sedation for your dental treatment?

Consent & Acknowledgment

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that providing

Patient / Guardian Signature: _____ Date: _____

 reception@thomasdentalgroup.net

 (330) 492 - 1730

 thomasdentalgroup.net

 4097 Fulton Drive NW Canton, Ohio 44718



HIPAA NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT & CONSENT

Patient Name: _____ Date of Birth: _____

Our dental office is committed to protecting the privacy of your protected health information (PHI). Federal law requires us to provide a Notice of Privacy Practices describing how your information may be used and disclosed.

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Consent

I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations, including appointment reminders and insurance processing.

I consent to the use and disclosure of my protected health information.

Communication Preferences (optional)

Phone Voicemail Text Email

Preferred Contact: _____

Authorization to Discuss Information (optional)

Name: _____ Relationship: _____

Patient / Parent / Guardian Signature: _____ Date: _____

Office Use Only (if acknowledgment refused)

Reason: _____ Staff Initials: _____ Date: _____



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FINANCIAL AGREEMENT & PATIENT RESPONSIBILITY

I understand that payment for dental services is due at the time services are rendered unless prior arrangements have been made. I agree that I am financially responsible for all charges incurred for dental services provided to me or my dependents.

I understand that dental insurance is a contract between me and my insurance company. As a courtesy, this office may submit insurance claims on my behalf; however, I am ultimately responsible for all charges not paid by insurance. Any estimates provided are not a guarantee of payment.

I understand that missed appointments or late cancellations affect our dental team, scheduled treatment time, and other patients seeking care. I agree to provide adequate notice if I am unable to keep my appointment.

I understand that returned checks may be subject to additional fees. Accounts with outstanding balances may be subject to collection efforts in accordance with Ohio law, and I agree to be responsible for reasonable costs of collection as permitted by law.

I have read and understand this financial agreement.

I agree to be financially responsible for all charges incurred.

Patient / Parent / Legal Guardian Signature: _____ Date: _____

Printed Name: _____

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DENTAL INSURANCE INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Phone Number: _____

PRIMARY DENTAL INSURANCE

Subscriber Name (if different from patient): _____

Subscriber Date of Birth: _____

Relationship to Patient:

Self Spouse Parent Other

Insurance Company Name: _____

Insurance Company Phone: _____

Member / Subscriber ID #: _____

Group Number (if applicable): _____

Subscriber Employer / School: _____

SECONDARY DENTAL INSURANCE (if applicable)

Subscriber Name: _____

Relationship to Patient:

Self Spouse Parent Other

Insurance Company Name: _____

Insurance Company Phone: _____

Member / Subscriber ID #: _____

Group Number: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize the release of dental and insurance information necessary to process insurance claims.

I authorize payment of dental insurance benefits directly to this dental office, if applicable.

I understand that insurance coverage is a contract between myself and my insurance company and that I am ultimately responsible for all charges not paid by insurance.

Patient / Parent / Legal Guardian Signature: _____ Date: _____

Printed Name: _____