Amanda McCauley-Thornberry, DMD

Jacquline Cecil, DMD

Patient Form

Name:_____ **Preferred Name**:_____

Birthdate: _____ **Social Security Number**:_____

Address: _____**City**: _____ **State**: _____ **Zip**:_____

Preferred Phone: _____ **Email**:_____

Dental Insurance:_____ **Subscriber's Employer:**_____

Subscriber's Name:_____ **Subscriber's Birthday:** _____

Subscriber's Social Security #_____ (Please provide your card.)

Please check if your medical history includes any of the following conditions:

- Do you have any dental concerns today? Yes No
  If yes, please explain: _____
- Who is your primary healthcare provider? _____Phone Number:_____
- Have you been admitted to a hospital or needed emergency care since your last visit? Yes No
  If yes, please explain:_____
- Have you had surgery since your last visit? Yes No
  If yes, please explain: _____
- Do you have any known allergies, allergies to medications, allergy to latex, allergy to nickle/metals? Yes No
  If yes, please explain:_____

What Medications are you currently taking? Prescribed and OTC. (You may provide a list.)

_____

_____

_____

Does your medical history include any of the following:

Yes	No		Yes	No		Yes	No	
___	___	Prosthetic Heart Valve	___	___	Respiratory Problems	___	___	Abnormal Papsmear
___	___	Artificial Joints	___	___	Sinus Problems	___	___	Osteoporosis
___	___	Pace Maker	___	___	Asthma	___	___	Take(n) Bisphosphonates
___	___	Heart Disease	___	___	COPD	___	___	Anemia/Blood Disease
___	___	Heart Attack	___	___	Epilepsy or Seizures	___	___	Cancer/Radiation treatments
___	___	Stroke	___	___	Anxiety	___	___	Dementia or Alzheimer's
___	___	Diabetes	___	___	Depression	___	___	Hepatitis
___	___	Kidney Problems	___	___	Autoimmune Disease	___	___	HIV
___	___	Sleep Apnea	___	___	Currently Pregnant	___	___	Cold Sores
___	___	Liver Problems	___	___	Currently Nursing			

Emergency Contact:_____ Relationship:_____ Phone:_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided. I fully understand I am solely responsible for any balance not paid by my insurance company. By signing this form, I agree to the Health Insurance Portability and Accountibility Act of 1996 (HIPAA) which requires that health providers keep your medical and dental information private. (Copy provided upon request.)

Patient Signature:_____ **Date:**_____