MICHAEL C. TOMS, DDS, MS
Implant Dentistry & Periodontics

Michael C. Toms, D.D.S., M.S.
5532 Muddy Creek Road, Cincinnati, Ohio 45238
(513) 922-7300

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Today's Date _____

Patient Name _____ Middle ___ Preferred _____

Date of Birth _____Gender _____ Marital Status_____

Home Address _____

Home Phone _____ Cell Phone _____

Email _____ Social Security # _____

Primary Physician _____ Phone Number _____

Last Physical Examination Date _____ Primary Dentist _____

Yes	No	Are you currently experiencing dental pain? How long? _____
Yes	No	Do you consider yourself in good dental health?
Yes	No	Do you think that your teeth are affecting your health in any way?
Yes	No	Are you dissatisfied with the appearance of your teeth?
Yes	No	Are you dissatisfied with your chewing ability?
Yes	No	Have you noticed any loosening in your teeth?
Yes	No	Does food tend to become caught in your teeth?
Yes	No	Do you suffer from pain and/or swelling of your gums?
Yes	No	Do you have an unpleasant odor or taste in your mouth?
Yes	No	Did either your mother or father lose all of their natural teeth?
Yes	No	Sensitivity? To… ( ) Sweets ( ) Hot ( ) Cold
Yes	No	Do you feel apprehensive when you are having dental treatment?
Yes	No	Does the fear of pain make you postpone your dental treatment?
Yes	No	Is it important for you to keep your natural teeth?
Yes	No	Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

Do you:

____ Clench or grind your teeth while awake or asleep? ____ Bite your lips or cheeks regularly?

____ Hold foreign objects with your teeth? ____ Breathe primarily through your mouth?

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When did you last have your teeth cleaned and where? _____

How often and when do you brush your teeth? _____

Do you use: Manual/Hand toothbrush ( ) Electric toothbrush ( ) Both ( )

Is your toothbrush: Soft ( ) Medium ( ) Hard ( )

What else do you use to clean your teeth? Floss ( ) Toothpick ( ) Waterpik ( ) Other ( ).

How often? _____

Yes No Are you taking any blood thinners? (*ie: Coumadin/Plavix)*, _____

Yes No Are you taking any vitamins or herbal supplements? _____

Yes No Do you smoke? How much? _____PPD. How Often? _____

Yes No Do you drink alcohol? How much? _____ How Often? _____

Yes No Have you ever had any problems with surgery?

Do you have or have you ever had: ***(Please Check)***

_____ Ulcers (Stomach or Duodenal)
_____ Heart murmur/mitral valve prolapse
_____ Heart Attack
_____ Arteriosclerosis
_____ Diabetes If so, Type A ( ) Type B ( )
_____ Stroke
_____ AIDS/HIV+
_____ Anemia/blood disorder/Hemophilia
_____ Radiation therapy/Chemotherapy
_____ Cancer
_____ Artificial Joints
_____ Artificial heart valves
_____ Frequent Headaches
_____ Psychiatric care
_____ Frequent fractures or dislocations
_____ Condition requiring cortisone/steroids
_____ Jaw Pain
_____ Hepatitis, jaundice, or other liver disease
_____ Epilepsy, seizures, convulsions, fainting
_____ Shortness of breath or chest pains upon exertion
_____ Food Allergies? _____

_____ Osteoporosis
_____ Kidney or bladder trouble
_____ High or low blood pressure
_____ Thyroid Disease
_____ Back problems
_____ Asthma or difficulty breathing
_____ Herpes
_____ Chemical dependency
_____ Arthritis or Rheumatism
_____ Painful or swollen joints
_____ Depression
_____ Rashes or skin disorders
_____ Dizziness or lightheadedness
_____ Sinus problems
_____ Birth Control Medication
_____ Sexually transmitted disease
_____ Pregnant
_____ Jaw Pain
_____ TB, COPD, Emphysema

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Preferred Pharmacy _____

Pharmacy Phone Number _____

Do you take a Pre-Medication? If so, have you taken it today? Yes No

Medication List

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Primary Dental Insurance Information:

Subscriber's Name _____ Subscriber's Phone Number _____
Subscriber's Date of Birth _____ Subscriber's SS Number _____
Employer Name _____ Employer Phone Number _____
Insurance Company Name _____ Insurance Phone Number _____
Subscriber ID Number _____ Insurance Group Number _____

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Financial and Information Policy

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor immediately. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.
I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that all payments must be made in full to the provider before any treatment/services are provided.

Signature _____ Date _____

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that I may request in writing that Dr. Michael C. Toms D.D.S., M.S. (the "Practice") restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the practice is not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By initialing the following, I am giving the practice the authority to speak with those individuals indicated below whom I have authorized regarding my treatment and the financials for my treatment.
_____Right to correspond with family member(s) as listed _____
_____Right to correspond with all doctor's office involved with treatment

Printed Name of Patient: _____
Signature of Patient/Guardian:_____
Relationship to Patient: _____
Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason