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