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

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.

Name: _____ Today's Date: _____

Home Address: _____

Home/Cell Phone_____ Date of Birth: _____

Email: _____ Social Security Number: _____

Height _____ Weight _____ Gender _____ Marital Status (Please Circle): ☐ Married ☐ Single ☐ Other

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer's Name and Address: _____

Business Phone: _____ Occupation: _____

Primary Physician: _____ Phone: _____

Address:_____

Last Physical Examination Date: _____

Primary Dentist: _____ Phone: _____

Address:_____

Date of Last Dental Treatment: _____ What was done? _____

Who may we thank for referring you to the office? _____

Give your reason(s) for seeking periodontal treatment: _____

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: _____

Member ID Number: _____ Insurance Group Number: _____

Name: _____ Date: _____

Medical History *(Circle One)*

☐ Yes No ☐ Are you now under the regular care of a physican?
If so, for what?_____
☐ Yes No ☐ Have you had any major operations, hospitalization or illnesses?
☐ Yes No ☐ If so, for what? _____
☐ Yes No ☐ Are you taking bisphosphonates? *(ie: Fosamax, Bonvia, Reclast)* _____
☐ Yes No ☐ Are you taking any blood thinners? *(ie: Coumadin/Plavix)* _____
☐ Yes No ☐ Are you taking any vitamins or herbal medications? _____
☐ Yes No ☐ Do you smoke? How Much: _____ How Often? _____
☐ Yes No ☐ Do you drink alcohol? How Much: _____ How Often? _____
☐ Yes No ☐ Have you ever had any problems with surgery or anesthesia?
☐ Yes No ☐ Are you taking any pills, medication or drugs?
If so, please list _____
_____
_____

Have you ever had a reaction to any of the following: (Please Check)

☐ Penicillin
☐ Sulfa Drugs
☐ Codeine
☐ Aspirin
☐ Bisphosphonates
☐ Sleeping pills (barbiturates)
☐ Tetracycline
☐ Dental anesthetic (Novocain)
☐ Nitrous oxide (laughing gas)
☐ Latex

Other Allergies:_____

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

☐ Rheumatic fever
☐ Heart murmur/mitral valve prolapse
☐ Heart Attack
☐ Arteriosclerosis
☐ Diabetes
☐ Stroke
☐ AIDS/HIV+
☐ Anemia/Hemophilia/blood disorder
☐ Tumors and growths
☐ Radiation therapy/Chemotherapy
☐ Artificial heart valves
☐ Frequent Headaches
☐ Jaw Pain
☐ Artificial Joints
☐ Psychiatric care
☐ Pregnant
☐ Frequent fractures or dislocations
☐ Condition requiring cortisone/steriods
☐ Hepatitis, jaundice, or other liver disease
☐ Osteoporosis
☐ Ulcers (stomach or duodenal)
☐ 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
☐ Rash or skin disorders
☐ Dizziness or light headedness
☐ Sinus problems
☐ Depression
☐ Sexually related disease
☐ Shortness of breath or chest pains upon exertion
☐ Birth Control Medication
☐ Cancer
☐ Tuberculosis, COPD, emphysema, lung disease
☐ Food Allergies: _____

Name: _____ Date: _____

Dental History

☐ Yes ☐ No Are you currently experiencing dental pain? For 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 your chewing ability?

☐ Yes ☐ No Have you noticed any loosening in your teeth?

Have you ever had:

☐ Orthodontic Treatment (braces, invisalign) ☐ Periodontal/gum treatment

☐ Oral Surgery (extractions, etc) ☐ A bite adjustment

☐ Night guard/bite plane or any other appliance

☐ Yes ☐ No Does food tend to become caught between your teeth?

☐ Yes ☐ No Do you suffer from pain and/or swelling of your gums?

☐ Yes ☐ No Do your gums often bleed when you brush your teeth?

☐ Yes ☐ No Do you have any unpleasant odor or taste in your mouth?

☐ Yes ☐ No Are you missing any teeth?

Reasons: Decay (☐) Gum Disease(☐) Other (☐) _____

☐ Yes ☐ No Did either your mother or father lose all his/her natural teeth?

☐ Yes ☐ No Sensitivity to Cold (☐) Hot (☐) Sweets (☐)

☐ 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?

When was your last appointment to get your teeth cleaned? _____

How often and when do you brush your teeth? _____

Do you use: Hand Toothbrush (☐) Electric Toothbrush (☐)

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

What else do you use to clean your teeth? (floss, toothpick, Waterpik, etc.) _____

How Often? _____

☐ Yes ☐ No Do you feel apprehensive when you are having a dental treatment?

☐ Yes ☐ No Would you like to use nitrous oxide (laughing gas)?

☐ Yes ☐ No Does the fear of pain make you postpone your dental treatment?

☐ Yes ☐ No Is it important to keep your teeth?

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. I understand that this information will be used by 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 paid by insurance or not.

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 acknowledge that I have obtained Michael C. Toms, DDS, MS (the "**Practice**") *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that the Practice restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand 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. I am also acknowledging that I have received a copy of the Practice's *Notice of Privacy Practices*.

_☐_ Right to correspond with family member(s) as listed

- Name: _____ Phone #: _____
- Name: _____ Phone #: _____

_☐_ Right to correspond with all doctor's office involved with treatment

_☐_ I also understand that all types of communication are not secure. Knowing this, I authorize MCT, DDS to communicate with me via: (please check) Cell Phone: _☐_ Text: _☐_ Email: _☐_

Printed Name of Patient: _____

Signature of Patient/Guardian: _____ Date: _____

Relationship to patient: _____

For 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: _____

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Patient Financial and Cancellation Policy

Finance Policy:

Michael C. Toms, DDS, MS strives to provide you with accurate information regarding your dental health.

Working with dental insurance companies has become increasingly difficult. It is the responsibility of the patient to fully understand the terms of their insurance policy. Ultimately our services are an out-of-pocket expense; *fees for service are due in full prior to treatment*.

As a courtesy, our insurance team will submit a claim on your behalf, and if your benefits are available, your dental insurance will reimburse you directly. We encourage you to understand your insurance coverage limits and the exact terms of your policy.

Cancellation Policy:

I understand that Michael C. Toms, DDS, MS requires a **24-hour notice** to cancel or reschedule an appointment. If an appointment is not cancelled with at least a 24-hour notice, a missed appointment fee of $25 will be charged. Please note, Monday appointments need to be cancelled by the end of the business day, Thursday, at 4:00pm.

After business hours voicemails, emails and texts do not qualify as next-day cancellation notices.

_____

Patient or Responsible Party Signature Date

Michael C. Toms, DDS, MS 5532 Muddy Creek Road, Cincinnati, Ohio 45238 office@yourhealthygums.com