Thomas P. Dunham, D.D.S.

CHILD PATIENT REGISTRATION

(Please Print)

CONTACT INFORMATION

Date _____ Primary Phone _____ Secondary Phone _____

Patient _____
Last Name, First Name, Middle Initial

Preferred Name _____ Family Email _____
Parent Email Address

Street Address _____ City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthdate _____ SSN# _____
(If Over 18 Years of Age)

Father's Name _____ SSN# _____ DOB _____
Last Name, First Name, Middle Initial

Father's Address _____ Phone _____ Cell _____

Father's Employer _____ Work _____ X _____
Name & Address *Extension*

Mother's Name _____ SSN# _____ DOB _____
Last Name, First Name, Middle Initial

Mother's Address _____ Phone _____ Cell _____

Mother's Employer _____ Work _____ X _____
Name & Address *Extension*

Are you a full-time student? ☐ Yes ☐ No If so, which school? _____

Primary Dental Insurance _____
Group or Policy Number and Phone

Secondary Dental Insurance _____
Group or Policy Number and Phone

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by Thomas P. Dunham, D.D.S. I further authorize release of any and all dental records as is necessary for third party reimbursement from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I realize this office bills my insurance company as a courtesy, however, I understand that I am ultimately responsible for any non-payment from my insurance company. I realize that there is a $40 return check fee. I'm aware this office charges a $40 broken appointment fee per hour, after my first broken appointment. I understand that there will be an interest fee of 1.5% per month on all remaining balances on my account over 60 days and that I will be responsible for attorney's fees of 33-1/3% and any other related costs of collection, should such action become necessary.

Patient/Guarantor Signature: _____ Relationship to Patient _____ Date _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

I agree that this dental practice may communicate with me electronically at the email address provided and that I can withdraw my consent to electronic communications by call the office.

Patient Signature: _____ Date: _____

In case of emergency, who should be notified? _____ Phone _____

To whom may we thank for referring you? _____

☐ Personal Referral ☐ Redmill Magazine ☐ Merchant Coupon ☐ Dunhamdental.com

☐ Office Location & Signage ☐ Lagomar Magazine ☐ Web Search ☐ Insurance Website

DENTAL HISTORY

Chief oral complaint _____ Date of last oral exam _____

Please indicate any of the following with a check

_____ Teeth sensitive to cold, heat sweets or pressure
_____ Bleeding gums
_____ Food Impaction
_____ Clenching or grinding
_____ Burning of tongue
_____ Swelling or lumps in mouth
_____ Bad Breath
_____ Pain around ear, TMJ
_____ Unusual sounds in ear while eating
_____ Unpleasant taste
_____ Unfavorable dental experience
_____ Complications from extractions
_____ Periodontal treatment
_____ Orthodontic treatment
_____ Mouth breathing
_____ Oral habits, i.e. fingernail biting cheek biting, thumb sucking, etc.
_____ Cigarettes, pipe, cigar smoking
_____ Texture of toothbrush (s, m, h)
_____ Daily brushing frequency
_____ Dental floss used daily
_____ Inter dental stimulators
_____ Water jet device
_____ Disclosing tablets or solution
_____ Frequent blister on lips or mouth
_____ Fluoride supplements
_____ Tobacco chewing

How important are your teeth on a scale of 1 - 10? _____
10 being most important

If we could offer a safe and effective method for whitening your teeth, would you be interested? _____

What would you change about your smile & dentition if you could? _____

How can we make receiving dental care as pleasant as possible for you? _____

I authorize the use of the Radiographs, Photographs or Video Tape of my case for presentations or publications of the doctor.

_____

MEDICAL HISTORY

Please indicate any of the following with a check

_____ Allergies to anesthetics
Which? _____
_____ Allergies to drugs
Which? _____
_____ Allergies to acrylic/latex/metals (please circle)
_____ Anemia or other blood disorders
_____ Artificial (prosthetic) Joints/Bones
If yes, when was joint/bone replaced? _____
_____ Asthma
_____ Blood transfusion, When? _____
_____ Chemotherapy
_____ Diabetes, Type? _____
_____ Emotional disorders
_____ Emphysema
_____ Epilepsy / Seizures
_____ Eye disorder
_____ Heart Ailments (heart murmur, mitral valve prolapse)
_____ Heart Attack
_____ Hepatitis, Type? _____
_____ High or low blood pressure
Which? _____
_____ HIV/AIDS
_____ Immunodeficiency
_____ Kidney Problems
_____ Liver Disease
_____ Neurological Problems
_____ Pregnant, # of weeks? _____
_____ Psychiatric care
_____ Radiation therapy
_____ Rheumatic Fever
_____ Rheumatoid Arthritis
_____ Sinus Problems
_____ Stroke, When? _____
_____ Thyroid Disease
_____ Tonsillitis
_____ Tuberculosis
_____ Ulcer or colitis
_____ Venereal disease

Please list any current medications you are taking _____

_____

Please describe any current medical condition that may need further explanation _____

_____

Please describe your general health _____

_____

Physician's name and phone number _____

Date of last physical exam _____