



T. Gregory Jacobs, D.D.S.  
Bryan R. Thatcher, D.M.D.

### **Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Subscriber \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Subscriber ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Employer \_\_\_\_\_ (Please present your card)

Whom may we thank for referring you? \_\_\_\_\_

### **Financial Policy**

*Please remember you are fully responsible for all fees charged by this office regardless of your dental benefits. At Jacobs and Thatcher Dentistry, we make every effort to provide you with the best of care, we offer many convenient financial options. Please speak with our front desk for more details. In addition, we work hand-in-hand with you to maximize your insurance reimbursement.*

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### **Authorization and Release**

*I certify that the above questions have been accurately answered and the information is correct to the best of my knowledge. Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office.*

*You have the right to restrict how Personal Health Information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.*

*By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in regards to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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**Patient Dental History**

**Name** \_\_\_\_\_

Do your gums bleed when you brush or floss?	Y N	Are your teeth sensitive to hot, cold, sweets or pressure?	Y N	Does food or floss catch between your teeth?	Y N
Is your mouth dry?	Y N	Have you had any periodontal treatment?	Y N	Have you had any orthodontic treatment?	Y N
Have you had any problems with previous dental work?	Y N	Do you have clicking, popping or discomfort in your jaw?	Y N	Do you clench or grind your teeth?	Y N
Do you have any sores or ulcers in your mouth?	Y N	Do you wear dentures or partials?	Y N	Have you had any head or mouth injuries?	Y N

Any specific dental concerns? \_\_\_\_\_

**Patient Medical History**

Do you currently have or ever had any of the following?

High or low blood pressure	Y N	Tuberculosis	Y N	AIDS or HIV	Y N
Blood Thinners	Y N	Stomach problems/Ulcers	Y N	Anemia	Y N
Heart Disease	Y N	Asthma	Y N	Autoimmune disease	Y N
Cardiac Pacemaker	Y N	Mental Health Disorder	Y N	Stroke	Y N
Chest pain/Angina	Y N	Epilepsy/Seizures/Fainting	Y N	Trouble sleeping/snoring	Y N
Congenital Heart Defect	Y N	Diabetes	Y N	Cancer	Y N
Infective Endocarditis	Y N	Chemotherapy/Radiation	Y N	Liver Disease	Y N
Artificial heart valve If yes, when was it replaced?	Y N	Osteoporosis If yes, which medication?	Y N	Artificial joints If yes, which joint & when?	Y N

\_\_\_\_\_

Allergies to medications, latex, nickel, etc? \_\_\_\_\_

Any additional medical information you would like the doctor to know about? \_\_\_\_\_

Please list any and ALL medications you are taking (or provide a current list).

- |          |          |          |          |
|----------|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ | 4. _____ |
| 5. _____ | 6. _____ | 7. _____ | 8. _____ |

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_