DR. RANDY THOMAS

Eaglesoft Medical History

Patient Name:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes	Cortisone Medicine	○ Yes	Hemophilia	○ Yes	Radiation Treatments	○ Yes
Alzheimer's Disease	○ Yes	Diabetes	○ Yes	Hepatitis A	○ Yes	Recent Weight Loss	○ Yes
Anaphylaxis	○ Yes	Drug Addiction	○ Yes	Hepatitis B or C	○ Yes	Renal Dialysis	○ Yes
Anemia	○ Yes	Easily Winded	○ Yes	Herpes	○ Yes	Rheumatic Fever	○ Yes
Angina	○ Yes	Emphysema	○ Yes	High Blood Pressure	○ Yes	Rheumatism	○ Yes
Arthritis/Gout	○ Yes	Epilepsy or Seizures	○ Yes	High Cholesterol	○ Yes	Scarlet Fever	○ Yes
Artificial Heart Valve	○ Yes	Excessive Bleeding	○ Yes	Hives or Rash	○ Yes	Shingles	○ Yes
Artificial Joint	○ Yes	Excessive Thirst	○ Yes	Hypoglycemia	○ Yes	Sickle Cell Disease	○ Yes
Asthma	○ Yes	Fainting Spells/Dizziness	○ Yes	Irregular Heartbeat	○ Yes	Sinus Trouble	○ Yes
Blood Disease	○ Yes	Frequent Cough	○ Yes	Kidney Problems	○ Yes	Spina Bifida	○ Yes
Blood Transfusion	○ Yes	Frequent Diarrhea	○ Yes	Leukemia	○ Yes	Stomach/Intestinal Disease	○ Yes
Breathing Problems	○ Yes	Frequent Headaches	○ Yes	Liver Disease	○ Yes	Stroke	○ Yes
Bruise Easily	○ Yes	Genital Herpes	○ Yes	Low Blood Pressure	○ Yes	Swelling of Limbs	○ Yes
Cancer	○ Yes	Glaucoma	○ Yes	Lung Disease	○ Yes	Thyroid Disease	○ Yes
Chemotherapy	○ Yes	Hay Fever	○ Yes	Mitral Valve Prolapse	○ Yes	Tonsillitis	○ Yes
Chest Pains	○ Yes	Heart Attack/Failure	○ Yes	Osteoporosis	○ Yes	Tuberculosis	○ Yes
Cold Sores/Fever Blisters	○ Yes	Heart Murmur	○ Yes	Pain in Jaw Joints	○ Yes	Tumors or Growths	○ Yes
Congenital Heart Disorder	○ Yes	Heart Pacemaker	○ Yes	Parathyroid Disease	○ Yes	Ulcers	○ Yes
Convulsions	○ Yes	Heart Trouble/Disease	○ Yes	Psychiatric Care	○ Yes	Venereal Disease	○ Yes
						Yellow Jaundice	○ Yes

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

Randy P. Thomas, D.M.D.
Jamie T. Wing, D.D.S.

Date_____

PATIENT INFORMATION:

Name_____

Date of Birth_____ Sex _____M_____F Marital Status _____M_____S_____D_____W

Social Security #_____Employer_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Mobile Phone Number_____ E-mail Address_____

Text? Yes / No

SPOUSE/PARENT INFORMATION:

Name_____

Mailing Address_____

City_____ State_____ Zip_____

Social Security #_____ Date of Birth_____

Employer_____ Work Phone Number_____

EMERGENCY INFORMATION:

Contact (Someone who DOES NOT live in your household) _____

Relationship_____ Phone Number_____

PRIMARY DENTAL INSURANCE:

(Please present card to receptionist so a copy can be made.)

Policyholder Name_____ Relationship_____

Employer _____ Insurance Company_____

Social Security # _____ Date of Birth _____

Insurance Group # _____Policy Holder ID# _____

SECONDARY DENTAL INSURANCE:

(Please present card to receptionist so a copy can be made.)

Policyholder Name _____Relationship_____

Employer _____Insurance Company_____

Social Security # _____ Date of Birth _____

Insurance Group # _____Policy Holder ID# _____

DENTAL HISTORY:

Former Dentist _____ Phone Number_____

Date of Last Dental Care _____ Date of Last Dental X-rays _____

Whom may we thank for referring you to our office _____

Randy Thomas, D.M.D
Office Policy

Due to the increase in the number of broken appointments Dr. Thomas requires a twenty-four hour cancellations notice of all appointments, failure to abide by this policy could result in a minimum charge of $25.00 up to a maximum of $75.00 billed to your account.

There are over 1,000 insurance plans in America, therefore, it is impossible for our office to know the specifics of your insurance plan. It is the responsibility of the patient to know and understand their dental insurance policy. Also it is the responsibility of the patient to provide Dr. Thomas and his staff with all insurance information. As a service to our patients we will file your dental insurance claims. Dr. Thomas requires that your ESTIMATED balance be paid at the time of service. If for any reason the remaining balance is not paid by your insurance carrier you will be responsible for the remaining balance.

PLEASE READ, SIGN AND DATE THE FOLLOWING:

A. I certify that the information given on this form is true and correct.
B. I authorize dental treatment to be rendered by Dr. Randy Thomas and his dental office staff.
C. I authorize the release of any information relating to my dental treatment for insurance and/or medical purposes.
D. I understand payment in full is due at the time of service.
E. I understand that a finance charge of 1.5% will be added to any unpaid balance after sixty (60) days from date of service.
F. I understand and agree to pay all cost of collections of this account including, but not limited to reasonable attorney's fees, which the office of Dr. Randy Thomas incurs by reason of my nonpayment of this account.
G. I understand that it is my responsibility to know and understand the benefits of my insurance policy.
H. I have received a HIPAA Notice of Privacy Practices form.

_____ _____

Signature Date

DR. RANDY THOMAS, DMD, PC
DR. JAMIE THOMAS WING, DDS
108 SOUTH CENTRAL AVE
PO BOX 349
CHURCH HILL, TN 37642

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/01/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family, Friends, and Persons Involved in Care: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Court Orders and Subpoenas: We may disclose information in response to an appropriate court order or subpoena.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.