MARTIN THOMPSON D.D.S
2575 CIMARRON, SUITE 100
LAS VEGAS, NV 89117
(702) 363-1500

(Confidential for our files)

PERSONAL INFORMATION

Patient Name _____ Spouse _____
Patient SS# _____ Spouse SS# _____
Patient birth date _____ Spouse birth date _____
Person responsible for account _____
Address _____ Home phone _____
State _____ Zip Code _____ Work phone _____
Referred by _____ Cell Phone _____ Pager _____

EMPLOYER AND INSURANCE INFORMATION

PRIMARY DENTAL COVERAGE

Employee _____
Employer _____
Insurance Co. _____
Insurance Co. phone _____
Address _____
State _____ Zip Code _____

SECONDARY DENTAL COVERAGE

Employee _____
Employer _____
Insurance Co. _____
Insurance Co. phone _____
Address _____
State _____ Zip _____

HEALTH HISTORY (PLEASE INDICATE)

HEART	YES	NO
Mitral valve prolapse	____	____
Rheumatic fever	____	____
Heart Murmur	____	____
Heart attack (date_____)	____	____
High blood pressure	____	____
Low blood pressure	____	____
Angina	____	____
Congenital heart disease	____	____
Artificial valves	____	____
Pacemaker	____	____
Heart surgery (date_____)	____	____

DIGESTIVE SYSTEM		
Hepatitis	____	____
Jaundice	____	____
Ulcer	____	____

RESPIRATORY		
Tuberculosis	____	____
Emphysema	____	____
Asthma	____	____
Smoker ?	____	____
Other : _____		

ENDOCORINE	YES	NO
Diabetes	____	____
Thyroid condition	____	____
Steroid Therapy	____	____

URINARY/REPRODUCTIVE		
Kidney disease	____	____
Venereal disease	____	____
Syphilis	____	____

BONE		
Arthritis		
Artificial joints	____	____
Pins/Plates	____	____
Osteoporosis	____	____
TMJ	____	____

BLOOD		
Bleeding tendency	____	____
Anemia	____	____
Bruise easily	____	____
Transfusion	____	____
Sickle cell anemia	____	____
Hemophilia	____	____
HIV positive	____	____
Other : _____		

PLEASE TURN OVER

HEALTH HISTORY (CONTINUED)

NERVOUS SYSTEM	YES	NO
Stroke	____	____
Epilepsy	____	____
Numbness	____	____
Dizziness/fainting	____	____
Psychiatric treatment	____	____
Nervous disorders	____	____

NOSE	YES	NO
Frequent nose bleeds	____	____
Sinus problems	____	____
Throat		
Soreness/hoarseness	____	____
Cancer or tumor?	____	____

GENERAL		
Cancer	____	____
Chemotherapy	____	____
Radiation therapy		
Drug allergies _____		

EARS		
Loss of hearing	____	____
Ringing in your ear	____	____

WOMEN ONLY		
Pregnant ? (months _____)	____	____
Post menopausal	____	____
Birth control pills	____	____
Hysterectomy (date_____)	____	____

My doctor is _____ Phone # _____
Taking medications No_____Yes_____If yes, _____
Allergic to medications: _____
General health comments: _____
Medical history updated on: _____

GENERAL INFORMATION

What is your main concern with your teeth and mouth ? _____
Have you ever considered cosmetic dentistry ? _____
Have you ever been concerned about your breath ? _____
Do you ever get a bad taste in your mouth_____What kind? Blood_____Iron_____Other_____
Are you interested in improving your breath ? _____
Are you currently using anything for breath control ? _____
Prior unpleasant dental treatment or experience ? _____

CONSENT FOR TREATMENT: I hereby give authorization to the dentist in charge of the care of this patient whose name appears on this form to administer any treatment, such as anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

SIGNED _____ **DATE** _____

UNLESS OTHER ARRANGEMENTS ARE MADE, I AGREE TO PAY ALL SERVICES AT THE TIME SUCH SERVICES ARE RENDERED. IF COLLECTION SERVICES ARE REQUIRED, I FURTHER AGREE TO PAY ALL LEGAL FEES AND COSTS INCURRED IN COLLECTION. FOR THOSE WITH INSURANCE, I REALIZE THAT DR. THOMPSON IS NOT A DENTAL INSURANCE PROVIDER, MY INSURANCE IS MY RESPONSIBILITY.

SIGNED _____ **DATE** _____