THORNLEY DENTAL
Mark J. Thornley
104 E. 200 N.
Logan, UT 84321

WELCOME TO OUR OFFICE

Patient's Name _____ (Last) _____ (First) _____ (MI) Date _____

Gender _____

Preferred Name _____ Social Securtiy # _____ Birth Date _____

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Cell) _____ (Work) _____ Ext. _____

Email _____ OK to text message cell? ☐ Yes ☐ No

Best Time To Call _____ Preferred appointment times ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ TH

HEALTH HISTORY

Date of last dental visit _____ Reason for this visit _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmer
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other _____
- ☐ MEDICATIONS (Current) _____

Have you ever had any complications following dental treatment? _____
If yes, please explain _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain _____

Name of Physician _____ Phone Number _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature _____ ☐ Patient ☐ Parent/Gaurdian Date _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Dental Office

☐ Internet ☐ Yellow Pages ☐ Newspaper ☐ Mailer ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice _____

RESPONSIBLE PARTY INFORMATION

Name _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Other _____

Social Security # _____ Birth Date _____

Phone (Home) _____ (Cell) _____ (Work) _____ Ext. _____

Address _____ Apartment # _____

City _____ State _____ Zip Code _____

EMPLOYMENT INFORMATION

The following is for ☐ the patient ☐ the person responsible for payment

Employer Name _____ Phone _____

INSURANCE INFORMATION

PRIMARY

Name of Insured _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID # _____ Group # _____

Insured's Address _____

Insured's Employer Name _____

Address _____

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

_____

SECONDARY

Name of Insured _____ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____

Insured's Employer Name _____

Address _____

Patient's relationship to insured ☐ Self Spouse ☐ Child ☐ Other

Insurance Plan Name and Address _____

_____

CONSENT OF SERVICE

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date _____ Relationship to Patient _____

Signature of patient, parent or gaurdian

_____ Date _____ Relationship to Patient _____

Signature of guarantor of payment/responsible party