



TOMASE DENTAL CARE

Tomase Dental Care

7616 Kings Pointe Rd.
Toledo, OH 43617
(419) 474-5858
drtomase.com

Welcome Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____
 Address: _____ City: _____ State/Zip: _____
 Employer: _____ Address: _____ Occupation: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____ Email: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc. Sec: _____
 Names and ages of family members: _____
 Do all family members live at the same address? _____
 Emergency Contact: _____ Address: _____ Phone: _____ Relationship _____
 Who may we thank for referring you to our office?: _____

Spouse Information

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____
 Address: _____ City: _____ State/Zip: _____
 Employer: _____ Address: _____ Occupation: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____ Email: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc. Sec: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
 Address: _____ Address (2): _____
 City: _____ State/Zip: _____ Employer: _____
 Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____ Email: _____
 Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
 Birth Date: _____ Age: _____ Soc. Sec: _____
 Responsible Party is also a policy holder for Patient Primary Insurance Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of insured: _____
 Insured Soc. Sec: _____
 Employer: _____
 Address: _____
 Address (2): _____
 City, State, Zip: _____

Your Relationship to Insured: Self Spouse Child Other
 Insured Birth Date: _____
 Insurance Company: _____
 Address: _____
 Address (2): _____
 City, State, Zip: _____

Secondary Insurance Information

Name of insured: _____
 Insured Soc. Sec: _____
 Employer: _____
 Address: _____
 Address (2): _____
 City, State, Zip: _____

Your Relationship to Insured: Self Spouse Child Other
 Insured Birth Date: _____
 Insurance Company: _____
 Address: _____
 Address (2): _____
 City, State, Zip: _____

Dental History

Reason for visit today _____

Former Dentist _____

City/State _____ Phone _____

Date of last dental visit _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you have any of the following:

Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous extractions <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	if yes, when _____
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss _____
	Loose teeth, broken teeth or fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush _____
	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like your teeth whiter? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there anything you wish you could change about your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No
	if yes, when _____	_____
	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
	if yes, when _____	

Medical History

Name of Primary Care Physician _____ Address _____ Phone _____

Date of last physical exam _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you have or have you ever had a drug/alcohol addiction? Yes No If yes, please explain: _____

Do you use tobacco? Yes No If yes, Cigarette Pipe/Cigar Smokeless tobacco

Additional information so that we may give you the best possible care _____

Please answer all questions

Cardiovascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Bacterial Endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperthyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No	Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive: Thirst/Urination <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemic <input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/Alcohol Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No
High/Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problems/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous/Anxiety Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke CVA/MIA <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Others:
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contacts <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Auto Immune Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogen Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Lichen Planus <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives/Rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Corticisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes I, II, Genital <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
Human Papilloma Virus (HPV) <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis A, B, C <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually Transmitted Disease <input type="checkbox"/> Yes <input type="checkbox"/> No		Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
		Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
		Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Additional Medical Information

Bisphosphonates*: Do you take Yes No Have you taken Yes No Do plan to take Yes No
(*drugs used to treat bone loss, osteoporosis, metastatic cancer, multiple myeloma, breast cancer, prostate cancer and pagets disease) (Example: Actonel, Aredia, Boniva Fosamax)

If yes to Bisphosphonates, do you take it Orally Yes No IV Yes No Drug's Name _____

How long? _____ Dosage _____ Diagnosis _____

Prescribing Physician's Name: _____ Address: _____ Phone: _____

Do you have a prosthetic (Artificial) Yes No _____ Knee _____ Hip _____ Other _____

Name of Orthopedic Surgeon: _____ Phone: _____ Date of Treatment: _____

Do you have diabetes? Yes No if yes, treated with No Medication Oral Medication Injected Medication

Do you have any of the following heart conditions? Yes No Prosthetic cardiac valve Previous infective endocarditis
 Specific congenital disease Heart transplant

Name of Cardiologist: _____ Phone: _____ Date of Treatment: _____

Woman: Are you

Pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Nickel Latex Local Anesthetics NSAIDS Sulfa Metals No known Allergies Other

If yes, please explain: _____

Please list all Prescription/OTC medications you are currently taking and reason (Including Herbal Supplements)

Medication	Reason

Please read and initial the following

Please read and initial the following

- _____ I understand that I am financially responsible for all charges whether or not paid by insurance.
- _____ I authorize Dr. Tomase and his staff to perform all necessary dental services.
- _____ I authorize Dr. Tomase to release and receive information to and from my physicians, and other health care providers.
- _____ I authorize the use of this signature on all insurance submissions.
- _____ I authorize the insurance company to pay Dr. Tomase all insurance benefits otherwise payable to me for services performed.
- _____ 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.

Date _____ Signature _____

B/P _____ P _____ Date _____

(STOP) THESE UPDATES ARE FOR FUTURE USE (STOP)

B/P _____ There HAS/HAS NOT been a change in my medical history. Initial _____ Date _____
P _____ If yes, please explain _____

B/P _____ There HAS/HAS NOT been a change in my medical history. Initial _____ Date _____
P _____ If yes, please explain _____

B/P _____ There HAS/HAS NOT been a change in my medical history. Initial _____ Date _____
P _____ If yes, please explain _____

B/P _____ There HAS/HAS NOT been a change in my medical history. Initial _____ Date _____
P _____ If yes, please explain _____