Office of Dr. Eli Thornock, DDS
299 Madison Ave N Suite A
Bainbridge Island, WA 98110
P: (206) 842-4848 I F: (206) 780-9646

Please fill out this form completely. The more information we have, the better we can care for you and your smile!

GENERAL INFORMATION – Please fill in all available info

Date_________________________

How did you learn about us? ☐Internet ☐Mail ☐Signs ☐Referred by____________________ ☐Other ___________________

Patient Name ___________________________________ Home Phone __________________ Cell Phone ___________________

Address ____ City _______________________ State ______ Zip __________

Date of Birth ____________________ Soc. Sec. # _______________________ Sex: M___ F___ Single___ Married___

Employer_____________________________________ Occupation_________________ Work Phone _____________________

E-mail ____ Guardian/Spouse's Name ______________________________

Emergency Contact (other than spouse) _______________________________________ Phone _________________________

INSURANCE INFORMATION – If you have a card, we can copy it.

Primary Dental Ins. ____

Group#/Employer ____

Name of Subscriber ____

Date of Birth ________________ Soc. Sec. #_________________________

Secondary Dental Ins. ____

Group#/Employer ____

Name of Subscriber ____

Date of Birth ________________ Soc. Sec. #_________________________

MEDICAL INFORMATION

Are you allergic to: Penicillin? Y N Codeine? Y N

Other allergies ____

Are you taking any medications/for what purpose? Y N _______________

____

Do you use tobacco? Y N

Are you subject to prolonged bleeding or bleeding disorders? Y N

Date of last physical exam____

Physician__________________________ Phone #_____________________

(Women) Are you pregnant? Y N How long?________

Are you taking oral contraceptives? Y N

MEDICAL HISTORY – Explain, if needed.

Y N Heart Disease/defect
Y N Rheumatic Fever
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N High Blood Pressure
Y N Diabetes
Y N Alcohol/Drug abuse
Y N Cancer/tumor or radiation therapy
Y N Epilepsy/Seizures
Y N Anemia
Y N Artificial joints/Prosthesis
Y N Ulcers
Y N Tuberculosis or lung disease
Y N Asthma or hay fever
Y N Sinus trouble
Y N Kidney Disease
Y N Hepatitis, jaundice or liver trouble
Y N Arthritis
Y N Glaucoma
Y N Herpes/cold sores
Y N Immune deficiency or HIV
Y N Surgery ___________________
Y N Other ______________________

DENTAL HISTORY – To assist us in providing dental care suited to your needs, please provide us with some information:

Date of your last dental visit? _______________ Reason for your visit today? ____

Do you have any specific dental concerns? ____

Are you experiencing pain? Y N Are you anxious about the dentist? Y N How often? Brush________ Floss________

Are you happy with the appearance of your smile? Y N What might you like to improve, if anything? __________________

Do you have any specific requests or needs that we can accommodate? ____

Please see reverse side to complete form. ➔➔➔

We appreciate the opportunity to serve you. Our intent is to provide you the finest care possible while ensuring that you fully understand our procedures, treatment and payment arrangements.

Payments: If you do not have insurance, please be prepared to fully cover the fees for each visit. Our office accepts cash, check, Visa, MasterCard, Discover and American Express.

Cancel Short Notice/No Show Policy: In an effort to keep cost down, understand that our office has a cancel short notice policy in place and that you are required to contact our office 24 hours in advance to cancel an appointment. If you neglect to do so, a fee of $25.00 per half hour of scheduled treatment can be assessed to your account.

Insurance: As a courtesy to our patients, we will submit charges to your dental insurance. Co-payments must be made prior to treatment. It is now unlawful for a Doctor or office staff member to waive co-payments for any patient. (Health Insurance Portability and Protection Act, Section 231-H).

Please realize that professional services are rendered to the patient not the insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible directly to this office. We cannot render services on the assumption that the charges will be paid by the insurance company. However, we will help in any way we can.

I have reviewed the above policies; I authorize release of any information relating to my dependents or my claim. I understand that I am responsible for all costs of dental treatment.

I hereby authorize my insurance benefits be paid directly to Eli Thornock, DDS or Sound Smiles Dental otherwise payable to me.

______________________________________ __________________________

Signed (patient or parent if minor) Date