

MEINERS DENTISTRY

Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care.
 To help us meet all your dental healthcare needs, please fill out this form
 completely in ink. If you have any questions or need assistance, please ask us -
 we will be happy to help.

Patient Information (CONFIDENTIAL)

Soc. Sec. # _____
 Date _____
 Home Phone _____
 Name _____ Birthdate _____ Cell Phone _____
 Address _____ City _____ State _____ Zip _____
 Check Appropriate Box: Minor Single Married Divorced Widowed Separated E-mail _____
 Patient's or Parent's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent's Name _____ Employer _____ Work Phone _____
 If Patient is a Student, Name of School / College _____ City _____ State _____
 Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Patient Medical & Dental History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?.....	<input type="checkbox"/>	<input type="checkbox"/>	4. Are you allergic to or have had any reactions to the following?		
2. Have you ever been hospitalized for any surgical operation or serious illness?.....	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (eg. novacaine).....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Penicillin or other Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			Any Metals _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			Other Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			5. Women Only:		
_____			a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers...	<input type="checkbox"/>	<input type="checkbox"/>	Or use smokeless tobacco?..	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>						

7. Present dental needs _____
 8. Are you having any discomfort at this time? _____
 9. Please describe _____
 10. Are you aware of any swelling, sores, or lumps in your mouth? _____
 11. Are you pleased with the appearance of your teeth? _____
 12. If not, what would you like to change? _____

Over Please

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?... | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever had braces? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever had any prolonged bleeding following extractions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any head, neck or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Other comments: _____ | | |
| 6. Have you ever experienced any of the following problems in your jaw? | | | _____ | | |
| a) Clicking?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| b) Pain (joint, ear, side of face)?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| c) Difficulty in opening or closing?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| d) Difficulty in chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Union or Local # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Union or Local # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis, photographs and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

I would like to handle financial arrangements in the following manner: _____

*All accounts not paid in full within 30 days of billing shall bear interest at the rate of 1.5% per month.

X

Signature of patient or parent if minor