MERIDIAN DENTAL CENTER, P.C.

PATIENT NAME: ____ D.O.B: _________
(circle one) Single Married Divorced Widowed Child

Male or Female ____ HOME PHONE: _______________ WORK PHONE:___________________

CELL PHONE: __________________ EMAIL ADDRESS__________________________________

ADDRESS ____

CITY _______________________________ STATE _________________ ZIP ______________________

SOCIAL SECURITY # __________________ DRIVERS LICENSE # ______________________

(IF CHILD; RESPONSIBLE PARTY____)

EMPLOYED BY ___________________________________ POSITION __________________________

SPOUSE NAME ____ DOB _______________________

SOCIAL SECURITY NUMBER __________________________ EMPLOYED BY __________________

REFFERED BY _____________ IN CASE OF EMERGENCY NOTIFY___________________________

WHO WILL PAY FOR THIS ACCOUNT ____

INSURANCE INFORMATION:

NAME OF INSURANCE CO. ____
GROUP NUMBER ______________________ POLICY NUMBER __________________DOB________
NAME OF POLICYHOLDER __________________________________ SSN ______________________

SECONDARY INSURANCE- NAME OF INSURANCE CO. ___________________________________
GROUP NUMBER _______________________ POLICY NUMBER _________________DOB________
NAME OF POLICY HOLDER _________________________________ SSN ______________________

- **We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.**

- **MISSED APPOINTMENTS-A $30.00 charge will be made for each missed or cancelled appointment WITHOUT 24 hours notice. CHECK FEE- A $25.00 charge will be made for insufficient fund checks.**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Treatment may be stopped after notifying patient or parent with no refund of money: for example; poor pay, habitually missed appointments, failure to cooperate in treatment.**

- **I authorize the Dentists and their staff to perform any necessary services needed during diagnosis and treatment.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Signature ____Date_____/___/_____
____Adult patient ___Parent or Guardian ___Spouse

Dr. Signature____Date_____/___/_____

DENTAL HISTORY

ARE YOU HAVING DISCOMFORT AT THIS TIME? YES _____ NO ____ IF YES WHAT IS THE

NATURE OF YOUR DISCOMFORT? ____

HOW LONG SINCE YOU HAVE BEEN TO A DENTIST? ______________________________

WHAT WAS DONE THEN? ____

DID YOU HAVE X-RAYS? ____

HAVE YOU LOST ANY TEETH? ____

HAVE YOU HAD ANY COMPLICATIONS WITH EXTRACTIONS? _____________________

DO YOU HAVE BLEEDING GUMS? ____

DO YOU HAVE A FEAR OF THE DENTIST? ____________________________________

DO YOU SMOKE?________ HOW MUCH_________________ HOW LONG_____________

DO YOU USE SMOKELESS TOBACCO? ________ HOW MUCH __________ HOW LONG ________

Are you Breast Feeding_____________________ Are you taking Blood Thinners________________

MEDICAL HISTORY

PHYSICIANS NAME ___________________________________ TELEPHONE ______________

DATE OF LAST PHYSICAL EXAM ____

LIST CURRENT MEDICATIONS ____

____

ANY RECENT SURGERIES? ____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

___ HEART PROBLEM
___ HIGH BLOOD PRESSURE
___ LOW BLOOD PRESSURE
___ CIRCULATORY PROBLEMS
___ NERVOUS PROBLEMS
___ RADIATION TREATMENTS
___ EXCESSIVE BLEEDING
___ AIDS
___ HIV
___ TOTAL JOINT REPLACEMENT
___ HEART MURMUR
___ ANEMIA
___ ASTHMA
___ ARTHRITIS
___ DIABETES
___ HEPATITIS
___ MEASLES
___ MUMPS
___ PSYCHIATRIC CARE
___ RHEUMATIC FEVER
___ ARE YOU PREGNANT?

___ SCARLET FEVER
___ SINUS PROBLEMS
___ STROKE
___ TYPHOID FEVER
___ TONSILLITIS
___ TUBERCULOSIS
___ ULCER
___ VENEREAL DISEASE
NAME OF DISEASE ________________________

ARE YOU ALLERGIC TO:
___ ANESTHETICS
___ CODIEINE
___ SULFA DRUGS
___ PAIN MEDICATION
___ ASPIRIN
___ KEFLEX
___ IODINE
___ ERYTHROMYCIN
___ BARBITURATES
___ PENICILLIN/OTHER ______________________

MERIDIAN DENTAL CENTER

<u>HIPPA</u>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(copies available at reception desk)

You May Refuse to Sign This Acknowledgement

I, ____(Patient or guardian), have received a copy of this office's Notice of Privacy Practices.

____
Please Print Patient's Name

____
Your Signature (or Patient or guardian)

____
Today's Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

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