PATIENT MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? □ No □ Yes

If yes, please list: _____

Are you under a PHYSICIAN'S CARE now? □ No □ Yes

For what? _____

What MEDICATIONS (including over-the-counter) do you take? _____

_____

What SUPPLEMENTS (including herbal) do you take? _____

_____

Women: PREGNANT? □ No □ Yes, due date: _____

Do you SMOKE? □ No □ Yes; #Pack/Day _____ Other tobacco? _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Artificial Heart Valve	A.I.D.S./HIV Positive	Tuberculosis (TB)
Congenital Heart Lesions	Hepatitis A (Infectious)	Asthma
Heart Surgery/Heart Transplant	Hepatitis B (Serum)	Sinus Trouble
Artificial Joints (Hip, Knee)	Liver Disease	Allergies or Hives
Infective Endocarditis	Rheumatic Fever	Diabetes
Kidney Trouble	Hemophilia (Bleeding Problems)	Thyroid Disease
Mitral Valve Prolapse	Chemotherapy	Ulcers
Heart Disease or Attack	(Cancer, Leukemia)	Epilepsy/Seizures
High Blood Pressure	Radiation Treatment	Arthritis
Angina Pectoris	Fever Blisters	Glaucoma
Stroke	Venereal Disease (Syphillis,	Emphysema
Heart Murmur	Gonorrhea, etc.)	Alcoholism
Heart Pacemaker	Herpes	Drug Addiction

CIRCLE ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

Latex Allergy	Local Anesthetic	Penicillin
Aspirin	Codeine	Erythromycin
Nitrous Oxide (Gas)		

Are you aware of being allergic to any other medications or substances? _____

If yes, please list: _____

Is there any other Medical or Dental information that you feel we should be aware of? _____

YOUR PHYSICIAN: _____

PATIENT DENTAL HISTORY

HOW LONG since you have seen a Dentist? _____

Is your present dental health □ GOOD □ FAIR □ POOR

	YES	NO
Are you having PROBLEMS now?	□	□
Are you AFRAID OR NERVOUS about dental treatment?	□	□
Do your gums BLEED, feel TENDER or IRRITATED?	□	□
Are you teeth SENSITIVE to hot, cold, sweets, pressure?	□	□
Are you UNHAPPY with the APPEARANCE of your teeth?	□	□
Are you aware of GRINDING or CLENCHING your teeth?	□	□
Do you have HEADACHES, EARACHES or NECK PAINS?	□	□
Do you have DISCOLORED teeth that bother you?	□	□
Would you like your smile to LOOK BETTER or DIFFERENT?	□	□
Do you REGULARLY use DENTAL FLOSS?	□	□

How do you feel about your teeth? _____

FINANCIAL POLICIES

1.) **RESPONSIBLE PARTY**- The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless **written** permission to bill another party is presented to our office at the time of service.

2.) **COLLECTION COSTS**- I agree to pay any **attorney fees, court costs** and a **35%** Collection Fee if collection by a third party is necessary.

3.) **BAD CHECK CHARGE**- I understand that a **$25** charge will be added to my balance if any check is returned for insufficient funds.

4.) **MISSED APPOINTMENTS**- I understand there may be a **$35** charge for missed appointments without 24 hour notification.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnosis and treatment. I authorize **release of any information** including the diagnosis and records of any treatment rendered to me or my child to **insurance companies or health practitioners**. I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. I understand the **Financial Policies** and agree to be **responsible for payment** of all services rendered to me or my dependents.

SIGNATURE OF PATIENT or RESPONSIBLE PARTY:

_____ **DATE:** _____

MERIDIAN DENTAL CENTER REGISTRATION

Meridian Dental Center

Today's Date: _____

PATIENT INFORMATION

PATIENT'S NAME **Last**: _____ **First**: _____ **Middle Initial**: _____ **SEX**: M F **AGE**: ____

Soc. Sec. # _____ **BIRTHDATE** ___/____/____ If Patient is a Minor, Parent's or Guardian's Name_____

Whom may we thank for referring you to our office? □ Friend □ Relative □ Referring Physician □ Internet Website

□ Insurance Company □ Other: _____ Name: _____

RESPONSIBLE PARTY INFORMATION

NAME Last: _____ First: _____ Middle Initial: _____ MARITAL STATUS (circle) Single Married

SOCIAL SECURITY # _____ BIRTHDATE ___/____/____ RELATIONSHIP TO PATIENT _____

RESIDENCE Street Address _____ City _____ State _____ Zip _____

HOME PHONE (_____)_____ CELL (_____)_____ WORK (_____)_____ E-MAIL _____

EMPLOYER _____ OCCUPATION _____ NO. OF YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____

LAST FIRST MIDDLE

EMPLOYER _____ NO. YEARS EMPLOYED ____

OCCUPATION _____SOC. SEC. # _____

CELL PHONE (_____)_____BIRTHDATE ___/____/____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME _____

ADDRESS _____

CITY, STATE _____ PHONE (_____)_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured Name _____ Birthdate ___/____/____

Insurance Co. _____

Insurance Co. Address _____

Insured Employer _____

Insured Soc. Sec./ ID # _____ Group # _____

Please complete if you have double <u>dental</u> insurance coverage.

Insured Name _____ Birthdate ___/____/____

Insurance Co. _____

Insurance Co. Address _____

Insured Employer _____

Insured Soc. Sec./ ID # _____ Group # _____