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
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? _____
_____
_____
_____
_____

	Yes	No
4. Are you allergic to or have had any reactions to the following?		
Local Anesthetics (eg. novacaine)	☐	☐
_____	☐	☐
Penicillin or other Antibiotics _____	☐	☐
Any Metals _____	☐	☐
Other Allergies _____	☐	☐
5. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you taking birth control pills?	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	Yes	No
Heart Problems	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis / Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐

	Yes	No
Chest Pains	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Respiratory Problems	☐	☐
Other _____	☐	☐
Do you smoke?	☐	☐
Or use smokeless tobacco?	☐	☐

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
1. Do your gums bleed while brushing or flossing?...	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?.....	☐	☐
5. Have you had any head, neck or jaw injuries?.....	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
a)Clicking?.....	☐	☐
b) Pain (joint, ear, side of face)?.....	☐	☐
c) Difficulty in opening or closing?.....	☐	☐
d) Difficulty in chewing?.....	☐	☐
7. Do you have frequent headaches?.....	☐	☐
8. Do you clench or grind your teeth?.....	☐	☐
9. Have you ever had braces?.....	☐	☐
10. Have you ever had any prolonged bleeding following extractions?.....	☐	☐

11. Other comments: _____

_____

_____

_____

_____

_____

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