



Meader Family Dentistry

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(757) 424-1300 • FAX (757) 424-0219

PATIENT INFORMATION FORM

Name _____ Sex _____ Date Of Birth _____
Address _____ City _____ State _____ Zip _____
Phone _____ Cell # _____ Work# _____
Email _____ Social Security# _____
Employer _____ Title _____ How long? _____
Spouse's/ Partner Name _____ Phone # _____
Spouse's Employer _____ Title _____ How long? _____
Emergency Contact:
Name _____ Phone# _____
How did you hear about our office? _____
Referred by? _____

INSURANCE INFORMATION

Plan Name _____
Address _____
Phone# _____ Group# _____
ID# _____ Insured SSN# _____
Insured Name _____ Insured DOB _____

PLEASE READ AND INITIAL

If you are taking birth control pills, please be advised that some studies have shown them to be less effective or ineffective while taking certain antibiotics. Therefore, you should take necessary precautions if this applies to you. ____

In the case of accidental exposure to any body fluids, I as well as the health care worker, agree to be tested for any infectious diseases which may be transmitted through this exposure. (state law) ____

Recent evidence has surfaced that life-threatening results can occur from the interaction of non-prescription drugs, such as cocaine, with the local anesthesia administered in dental treatment. If you are taking ANY medication, prescribed or non-prescribed, it is ESSENTIAL that you inform the dentist prior to treatment. ____

AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I have authorized the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I hereby consent to treatment and realize that I am fully responsible for the fees related to this treatment. A 12% finance charge will be applied to balance over 60 days past due. In the event my account is in default and is referred to an attorney for collections. I agree to pay attorney's fees of 33 1/3% of the unpaid balance at time of referral.

Signature of Patient of Parent/Guardian: _____ Date: _____

DENTAL HISTORY

Reason for visit _____

Do you have problems with any of the following :

- Bad Breath
- Food Collection between teeth
- Periodontal Treatment
- Sensitivity to sweets
- Bleeding Gums
- Grinding or clenching teeth
- Sensitivity to cold/hot
- clicking or popping jaw
- loose teeth or broken filling
- sores or growths in mouth

How often do you brush? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

yes no

MEDICAL HEALTH HISTORY

Are you currently under physician care? yes no If yes, describe _____

Your physician's name _____ Phone# _____

Are you pregnant? yes no Nursing? yes no Taking birth control pills? yes no

Do you smoke, vape or use tobacco? yes no

Are you required to Pre-Medicate before any dental treatment? yes no

Do you have, or have you had any of the following ? (Please check any that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | Describe _____ | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atopic (Allergy Prone) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Thyroid Disease/Malfunction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease or | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | Malfunction | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Material Allergies | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Cortisone Treatments | (Latex, Wool, Metal, Chemicals) | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Nervous Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker/Heart Surgery | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Rapid Weight Gain/Loss | |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Radiation Treatment | |

LIST OF MEDICATIONS: _____

LIST OF DRUG ALLERGIES, IF ANY: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____ **STAFF:** _____