MERIDIEN
DENTAL

Name _____ I prefer to be called _____
Last First M.I. Mr./Mrs./Ms./Dr.

Male/Female Single/Married/Divorced/Widowed/Separated Social Security # _____

Birthdate ____/____/____ Age _____ Drivers License # _____

Home Address _____
Street City State Zip

Home Phone (___) _____ E-Mail _____

Work Phone (___) _____ Ext. _____ Best time to reach you at work _____ At home _____

Employer _____

Employer's Address _____
Street City State Zip

Cell Phone (___) _____ Whom may we thank for referring you? _____

Responsible Party/Spouse/Parent/Guardian Information

Name _____ Birthdate ____/____/____

Name _____ Social Security # _____

Work Phone (____) _____ Home Phone (____) _____

Employer _____ Occupation _____

Employer's Address _____
Street City State Zip

Insurance Information
Primary Insurance

Insurance Co. Name _____ Group or Policy# _____

Employer _____ Employee Name _____

Relation _____ Date of Birth ____/____/____ Social Security # ___–__–____

Secondary Coverage

Insurance Co. Name _____ Group or Policy # _____

Employer _____ Employee Name _____

Relation _____ Date of Birth ____/____/____ Social Security # _____

Continued on back

Dental History

Why have you come to the dentist today? _____

Are you happy with the way your smile looks Yes/No

If not, what would you change _____
_____

Do your gums bleed when you brush? Yes/No

Have you had periodontal disease/surgery? Yes/No

Medical History

Your current physical health is: Good / Fair / Poor

Are you currently under the care of a physician? Yes / No

Please explain: _____

_____

Physician's Name _____

Address _____

Phone (___) _____

Do you smoke or use tobacco in any other form? Yes / No

Do you have a personal physician? Yes / No

Ever used Phen-Fen, Redux, or Pondimin? Yes / No

FOR WOMEN: Are you taking birth control pills? Yes / No

Are you pregnant? Yes / No

Please mark "Yes" or "No" to indicate if you have any of the following: Yes/No

Y N	Abnormal Bleeding	Y N	Headaches	Y N	Cardiovascular Disease (✓ all that apply)
Y N	Alcohol or Drug Dependency	Y N	Hemophilia	☐	Angina
Y N	Anemia	Y N	Hepatitis	☐	Artificial Heart Valve
Y N	Arthritis	Y N	Liver Disease	☐	High Blood Pressure
Y N	Asthma	Y N	HIV+/AIDS	☐	Congenital Heart Defect
Y N	Artificial Bones or Joints	Y N	Kidney Problems	☐	Congestive Heart Failure
Y N	Blood Transfusions	Y N	Lupus	☐	Coronary Artery Disease
Y N	Cancer/Chemotherapy/Radiation	Y N	Neurological Disorder	☐	Damaged Heart Valve
Y N	Diabetes	Y N	Stroke	☐	Heart Attack
Y N	Difficulty Breathing	Y N	Sexually Transmitted Disease	☐	Heart Murmur
Y N	Emphysema	Y N	Sinus Trouble	☐	Mitral Valve Prolapse
Y N	Epilepsy	Y N	Thyroid Problems	☐	Pacemaker
Y N	Fainting Spells or Seizures	Y N	Tuberculosis (TB)	☐	Rheumatic Fever
Y N	Gastrointestinal Disease	Y N	Ulcers	☐	Rheumatic Heart Disease

Please list any medications you are currently taking: _____

Please list any other allergies: _____

Are you allergic to any of the following: Y N Codeine Y N Antibiotics Y N Latex
Y N Dental Anesthetics Y N Aspirin

Any other condition not listed that we should know about? _____

During your dental visits, when there is down time, would you prefer to:

A) Close your eyes and relax
B) Listen to some music
C) Watch a movie
D) Read a magazine

What is your favorite? band/artist: favorite TV show:

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment for services rendered, any deductible, and co-payment that my Insurance does not cover.

Signature_____ Date _____

Print Name _____

Please review Dental Material Fact Sheet and **initial here**: _____

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