Meadows
FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI

Gender: _____ Social Security #:_____ Birth Date:_____/_____/_____

Address _____
Street Apartment #

_____ Email: _____
City State Zip

Phone: (Home): _____ (Work): _____ (Cell): _____

Preferred Method of Contact:
❍E-mail ❍Home ❍Work ❍Cell

(Although oral health primarily involves your oral tissues and surrounding structures, your overall health and medical conditions influence the sequence and appropriate treatment of oral diseases. Your answers are important and kept confidential.)

Review of General and Oral Health (please X if you have or have had any of the following conditions)

- ❍ Abnormal Bleeding
- ❍ AIDS/HIV
- ❍ Allergy/Anaphylaxis
- ❍ Anemia
- ❍ Angina
- ❍ Alzheimer's Disease
- ❍ Anti-coagulant therapy
- ❍ Arthritis
- ❍ Artificial Heart Valve
- ❍ Artificial Joint
- ❍ Asthma
- ❍ Bisphosphonates therapy
- ❍ Bleeding Gums
- ❍ Blood Disease
- ❍ Blood Transfusion
- ❍ Breathing Problems
- ❍ Bruise Easily
- ❍ Cancer
- ❍ Canker Sores
- ❍ Cardiovascular Disease
- ❍ Chemotherapy
- ❍ Clench/grind your teeth
- ❍ Cold Sores
- ❍ Congenital Heart Defect
- ❍ C-PAP
- ❍ Dental Trauma
- ❍ Diabetes
- ❍ Dizziness
- ❍ Dry Mouth
- ❍ Eating Disorder
- ❍ Emphysema
- ❍ Epilepsy/Seizures
- ❍ Epinephrine Sensitive
- ❍ Excessive Bleeding
- ❍ Fainting
- ❍ Frequent Cough
- ❍ Frequent Diarrhea
- ❍ Frequent Headaches
- ❍ GE Reflux
- ❍ GI Problems
- ❍ Glaucoma
- ❍ Head Injuries
- ❍ Heart Attack
- ❍ Heart Disease
- ❍ Heart Murmur
- ❍ Hemophilia
- ❍ Hepatitis A, B, or C
- ❍ Hives/Rash
- ❍ Hypertension
- ❍ Hypoglycemia
- ❍ Irregular Heart Beats
- ❍ Immune Compromised
- ❍ Jaundice
- ❍ Jaw Popping/Clicking
- ❍ Kidney Problems
- ❍ Liver Disease
- ❍ Lock Jaw open/closed
- ❍ Low Blood Pressure
- ❍ Lung Disease
- ❍ Mental Health Disorders
- ❍ Migraines
- ❍ Mitral Valve Prolapse
- ❍ Osteoporosis
- ❍ Pace Maker
- ❍ Pain in Jaw Joint
- ❍ Periodontal Disease
- ❍ Pregnancy
- ❍ Psychiatric Care
- ❍ Radiation Treatments
- ❍ Recent Weight Changes
- ❍ Renal Dialysis
- ❍ Rheumatic Fever
- ❍ Rheumatism
- ❍ Sickle Cell Disease
- ❍ Seizures/Convulsions
- ❍ Shingles
- ❍ Sinus Trouble
- ❍ Sleep Apnea
- ❍ Stomach Problems
- ❍ STD
- ❍ Stroke
- ❍ Swollen Lymph Nodes
- ❍ Thyroid Disease
- ❍ TMD
- ❍ Tuberculosis
- ❍ Tumors or Growths
- ❍ Ulcers
- ❍ Venereal Disease

Do you have any other medical diseases, conditions, or problems not listed above? _____
_____

Primary Physician Name: _____**Preferred Pharmacy**: _____

Yes No

❑ ❑ Are you currently under the care of a physician? If yes, name of Physician(s)_____
condition(s) being treated _____

❑ ❑ Have you ever been hospitalized or had any operations? (please list operation(s) & year)
_____
_____

❑ ❑ Are you taking any medicine(s) including OTC or Herbal, if yes list the medication, dosage and how often the medicine(s) taken. _____
_____

❑ ❑ Have you ever taken IV or Oral Bisphosphonates (ex: Fosamax, Boniva, Zometa, Aredia etc.)?

❑ ❑ Are you allergic to any of the following?

❑ local anesthetics ❑ aspirin ❑ antibiotics ❑ codeine /narcotics ❑ latex ❑ metals(jewelry)

If yes specify the type of reaction _____

Women are you: ❑nursing ❑taking oral contraceptives or ❑ is there a chance you may be pregnant?

Oral Cancer Risk Factors

Yes	No	
❍	❍	Do you use tobacco? (smoke, chew, vape, snuff) if yes, how many pack(s)/day_____ # of years _____
❍	❍	Do you drink alcoholic beverages? If yes how often ❍socially ❍weekly ❍daily
❍	❍	Have you ever used drugs or substances for recreational purposes? If yes please explain_____

_____

Whom may we thank for referring you to our practice? _____

❍Friend ❍Relative ❍Specialist ❍Advertisement ❍Internet ❍Insurance Policy ❍Neighborhood

Insurance Information:

Primary

Name of insured: _____ Is insured a patient? ❍yes ❍no
Last First MI

Insured's Birth Date:_____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name:_____

Patient's relationship to insured: ❍Self ❍Spouse ❍Child ❍Other _____

Insurance Plan Name and Address: _____
_____

Secondary Insurance? Yes ❑ No ❑

Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment. I understand the above information is necessary to provide me with detail care in a safe and efficient manner.

The undersigned hereby authorize Dr. Polson and his staff to take x-rays, study models, photograph, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize and give consent to dental services between doctor and patient and/or parent or guardian to be necessary or advisable, including the use of local anesthesia and other medications as indicated. I certify to the above statements regarding any medical condition.

I authorize the dentist to release any information including the diagnosis and records or treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (fi any).

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (7) days of billing if credit shall be extended.

_____ _____

Signature of Patient, Parent or Guardian **Date**

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Oral Health/Dental Questionnaire

Dr. Preston Polson and the staff at **Meadows Family Dentistry** are committed to make your dental experience unique and personalized. We will help you understand your dental needs and together determine what treatment options are best.

Here are some things we are going to be talking about at your first visit. Please describe what best expresses how you feel about the following questions:

What is your immediate concern?_____

Are your teeth sensitive to cold, biting or are you experiencing any acute pain? _____

When was your last dental exam/cleaning?_____

How do you feel about your smile? Is there anything you would like to change about your smile?

_____

What expectations do you have for the dental office, staff and dentist?_____

_____

_____

Have you ever had or been told you need a periodontal or deep cleaning? _____

Are you anxious, fearful or have had a past dental experience that has created anxiety? _____

Do you take antibiotics before dental procedures? If so why?_____

_____

Do you have any family or friends that already come to our office? _____

Does your family have a current orthodontist? _____

Is there anything else you would like us to know in order to help you have a pleasant, comfortable experience and meet your expectations? _____

_____

_____

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Acknowledgement of important and required Office Policies for Dental Treatment

I, _____, have received a copy of the following Office Policies, Privacy Practices and Oral Health Testing at Meadows Family Dentistry as noted below.

Oral Health Testing

I have received a copy of this office's Oral Health Testing and am aware of the oral health options available to me

_____
(Initials)

❑ Yes, I am interested (check which tests you want)
- ❑ **MyPerioID PST** (risk of gum disease)
- ❑ **MyPerioPath** (identity bacteria triggering gum disease)
- ❑ **OraRisk HPV** (risk of oral cancer)

❑ Maybe, I would like to discuss it further

❑ No, I am not interested

Receipt of Notice of Privacy Practices
** You may refuse to sign this acknowledgement **

I have received a copy of this office's Notice of Privacy Practices and agree to the terms described in the policy.

Yes No
❑ ❑ _____
(Initials)

Authorization to Discuss Dental Treatment

I authorize Meadows Family Dentistry to discuss my dental treatment needs and finances with the following individuals:

_____

_____

Financial Policy Agreement

I have received a copy of this office's Financial Policy Agreement and agree to the terms outlined.

Yes No
❑ ❑ _____
(Initials)

Patient Signature: _____ Date: _____