Meadows
FAMILY DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender_____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Cell: _____E-mail:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

(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
- ❍ Arthritis
- ❍ Artificial Heart Valve
- ❍ Artificial Joint
- ❍ Asthma
- ❍ 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
- ❍ Dry Mouth
- ❍ Eating Disorder
- ❍ Emphysema
- ❍ Epilepsy/Seizures
- ❍ Epinephrine Sensitive
- ❍ Excessive Bleeding
- ❍ Frequent Cough
- ❍ Frequent Diarrhea
- ❍ Frequent Headaches
- ❍ GE Reflux
- ❍ GI Problems
- ❍ Glaucoma
- ❍ Heart Attack
- ❍ Heart Murmur
- ❍ Heart Conditions
- ❍ Hemophilia
- ❍ Hepatitis A, B, or C
- ❍ Hives/Rash
- ❍ Hypertension
- ❍ Hypoglycemia
- ❍ Irregular Heart Beats
- ❍ Immune Compromised
- ❍ Jaw Popping/Clicking
- ❍ Kidney Problems
- ❍ Liver Disease
- ❍ Lock Jaw open/closed
- ❍ Low Blood Pressure
- ❍ Lung Disease
- ❍ Migraines
- ❍ Mitral Valve Prolapse
- ❍ Mental Health Disorders
- ❍ Osteoporosis
- ❍ Pace Maker
- ❍ Pain in Jaw Joint
- ❍ Periodontal Disease
- ❍ Psychiatric Care
- ❍ Radiation Treatments
- ❍ Recent Weight Changes
- ❍ Renal Dialysis
- ❍ Rheumatic Fever
- ❍ Rheumatism
- ❍ Sickle Cell Disease
- ❍ Seizures/Convulsions
- ❍ Shingles
- ❍ Sinus Trouble
- ❍ Sleep Apnea
- ❍ STD
- ❍ Stroke
- ❍ Swollen Lymph Nodes
- ❍ Thyroid Disease
- ❍ TMD
- ❍ Tuberculosis
- ❍ Tumors or Growths
- ❍ Ulcers

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) and 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

❍ ❍ Do you use tobacco? (smoke, chew, 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

_____

REFERAL INFORMATION

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

▫Friend ▫ Relative ▫Dental Office ▫ Advertisement ▫ Internet ▫ Insurance Policy ▫Neighborhood

_____

Spouse or Responsible Party Information

The following is for: ▫ the patient's spouse ▫ the person responsible for payment

Name: _____

▫ Male ▫ Female ▫ Married ▫ Single ▫ Child ▫ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____

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: _____

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 change in my health, I will inform the doctors at the next appointment. I understand the above information is necessary to provide me with dental care in a safe and efficient manner.

The undersigned hereby authorizes Dr. Polson and his staff to take x-rays, study models, photographs, 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 medication 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 (if any).

A service charge of 1½% 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.

_____ Date:_____

Signature of Patient, Parent or Guardian

Oral Health & Dental Information

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 or check what best expresses how you feel about the following questions:

What is your immediate concern?_____

Tell us what you think is the present state of the health of your mouth?

_____

When was your last Dental Exam?_____

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

_____

What do you already know about our office and what are your expectations?

_____

How healthy do you want us to get your mouth?

❑ *"pain free"* ❑ *Average* ❑ *The best it can be*

Should you need treatment, at what point should we address it?

❑ *When a tooth hurts/breaks* ❑ *When something is worsening* ❑ *When something is not its best*

What quality of dentistry do you want us to recommend?

❑ *"Just patch it"* ❑ *Average* ❑ *Ideal/the Best*

We have the ability to look at your mouth from 3 different perspectives. Which combination of these would you like us to use for you?

❑ As a ***general*** *dentist* ❑ *As a* ***cosmetic*** *dentist* ❑ *As a* ***functional*** *dentist*

How do you feel about the appearance of your face and smile?

What qualities does it take to trust a dentist?

Tell us about your **good** dental experiences.

Have you had any bad experiences at the dentist?

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

What caused you to leave your last dental office?

Has time ever been a factor in getting your dental work done?

Has the cost of dental treatment been a concern for you?

What can we do to help you with these concerns?

Are your teeth sensitive?

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

Does your family have a current orthodontist? _____