Reviewed O
Scanned O
Entered O

Today's Date_____

Patient Name_____

I prefer to be called_____

SS#_____

PATIENT INFORMATION

Home Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ Sex ◯M ◯F Birthdate_____ Driver's License #_____

Email_____ Cell Phone (_____)_____

Employer_____ Occupation_____ Work Phone (_____)_____

Employer Address_____ City_____ State_____ Zip_____

Marital Status: ◯ Single ◯Married ◯Separated ◯Divorced ◯Widowed

Spouse or Parent's Name_____ Employer_____ Work Phone (_____)_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone (_____)_____

RESPONSIBLE PARTY

Name of Person Responsible

for this Account_____ SS#_____ Relation to Patient_____

Home Address_____ City_____ State_____ Zip_____

Home Phone (_____)_____ Birthdate_____ Driver's License #_____

Email_____ Cell Phone (_____)_____

Employer_____ Occupation_____ Work Phone (_____)_____

Employer Address_____ City_____ State_____ Zip_____

Currently a patient at our office? ◯Yes ◯No

PRIMARY DENTAL INSURANCE

Name of Insured_____ Relation to Patient_____

Birthdate_____ SS#_____

Employer_____ Work Phone (_____)_____ Date Employed_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group/policy #_____

Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Maximum Annual Benefit_____

SECONDARY DENTAL INSURANCE

Name of Insured_____ Relation to Patient_____

Birthdate_____ SS#_____

Employer_____ Work Phone (_____)_____ Date Employed_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ Group/policy #_____

Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Maximum Annual Benefit_____

PLEASE SIGN ON REVERSE

Reviewed O O O O
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Entered O O O O

Today's Date_____ **Phone #**_____

Patient Name_____ **Birthdate**_____

DENTAL HISTORY

Date of last dental care_____

Have you had any of the following:

◯ Bad breath
◯ Bleeding gums
◯ Clicking or popping jaw
◯ Food collection between teeth
◯ Grinding teeth
◯ Loose teeth or broken fillings
◯ Periodontal treatment
◯ Sensitivity to cold
◯ Sensitivity to hot
◯ Sensitivity to sweets
◯ Sensitivity when biting
◯ Sores or growths in your mouth

What are some questions about dentistry or your oral health that you have never had adequately answered?_____

_____

What, if anything, would you change about your smile?_____

_____

MEDICAL HISTORY

Family Physician_____ Office Phone (_____)_____

Are you currently under the care of a physician for a medical condition? ◯Yes ◯No
If yes, please explain:_____

Have you had any serious illnesses or operations? ◯Yes ◯No
If yes, please explain:_____

(Women) Are you pregnant? ◯Yes ◯No Nursing? ◯Yes ◯No

Check any conditions you currently have or have had in the past:

◯ Anemia or Hemophilia
◯ Arthritis
◯ **Artificial Heart Valve**
◯ **Artificial Joint (M/Y _____/_____)**
◯ Asthma or Hay Fever
◯ **Bacterial Endocarditis**
◯ Blood Transfusion
◯ Bruise Easily/Abnormal Bleeding
◯ Cancer or Tumor
◯ Canker Sores
◯ Chemical Dependency
◯ Chemotherapy/Radiation
◯ Chest Pain (Angina)
◯ Cortisone treatment
◯ Depression
◯ Diabetes
◯ Epilepsy or Seizures
◯ Fainting or Dizzy Spells
◯ Glaucoma
◯ Headaches
◯ Heart Attack or Stroke
◯ Heart Murmur
◯ Heart Surgery
◯ Hepatitis
◯ Herpes (any kind)
◯ **High Blood Pressure**
◯ HIV/AIDS
◯ Jaw Pain
◯ Kidney Disease
◯ Liver Disease
◯ Lung Disease
◯ **Pacemaker**
◯ Rheumatic Fever
◯ Shortness of Breath
◯ Skin Rashes or Hives
◯ Swelling of Ankles
◯ Thyroid Disease
◯ Tobacco Habit
◯ Tuberculosis
◯ Venereal Disease

Do you take aspirin or any other blood thinners? ◯Yes ◯No

Are you currently taking any prescription or over-the-counter medications? ◯ Yes ◯No
If yes, please list all medications with dosages:
_____
_____
_____
_____

Any allergies to the following:
Codiene ◯Yes ◯No
Latex ◯Yes ◯No
Dental Anesthetics ◯Yes ◯No
Penicillin ◯Yes ◯No
Other_____

AUTHORIZATION AND RELEASE

The information that I have given today is correct and complete to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I certify that I, and/or my dependents, have dental insurance coverage with_____ and assign all insurance benefits directly to Dr. Michael S. Mead Jr. I authorize Dr. Mead to use my signature on all insurancesubmissions and to release all information necessary to secure payment of benefits or to determine insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Printed name of Patient, Parent or Guardian Relation to Patient

Any changes to the above information? ◯Yes ◯No Signature_____ Date_____
Any changes to the above information? ◯Yes ◯No Signature_____ Date_____
Any changes to the above information? ◯Yes ◯No Signature_____ Date_____