MEADOWS DENTAL GROUP

PATIENT INFORMATION- ADULT

Patient Name:_____ Date:_____

DOB (DD/MM/YY):_____

Home Address:_____

Home Phone:_____Cell:_____

Work Phone:_____Employer:_____Occupation:_____

Email Address:_____

Spouse/Partner Name, if applicable:_____

Employer:_____Occupation:_____

Approx. date of last dental visit?_____

Procedure done at that visit?_____

Have you had any recent dental X-rays?_____

Any current dental problems?_____

Any current dental discomfort or pain?_____

Name of person or office, if any, who referred you?_____

Who is responsible for payment of this account?_____

Do you, or your spouse, or both have dental insurance?_____

If yes, please fill in the following section completely.

INSURANCE INFORMATION

Primary Coverage

Name of insured:_____

Is insured person a patient here?_____Insured's DOB:_____

Insurance plan name:_____

Group#:_____ID#:_____%covered:_____

Insured's employer's name:_____Phone#:_____

Patient's relationship to insured Self? Spouse? Child? Other?

Secondary Coverage

Name of insured:_____

Is insured person a patient here?_____Insured's DOB:_____

Insurance plan name:_____

Group#:_____ID#:_____%covered:_____

Insured's employer's name:_____Phone#:_____

Patient's relationship to insured Self? Spouse? Child? Other?

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HEALTH HISTORY

Do you have or have you had any of the following? (please check off those that apply to you)

____Arthritis

____Total joint replacement

____Blood disease

____High blood pressure

____Excessive bleeding/bruising

____Faint/Seizures/Epilepsy

____Congenital heart disease/Heart attack/Stroke

____Heart surgery/Prosthetic valve

____Pacemaker

____Diabetes

____Hepatitis/Jaundice/Liver disease

____Kidney Disease

____Cancer

____HIV/AIDS

____Radiation treatment

Do you take?

____Immuno-suppressive drugs

____Anticoagulants/Blood thinners/Aspirin

____Naturopathic remedies

____Mental illness/Mood disorder

____Anxiety

____Alzheimer's/Dementia

____Brain injury

____Osteoporosis

____Pregnancy: Due date:_____

____Respiratory problems/COPD/Asthma

____Hearing impairment

____Sensitivity to latex

Drug allergies (circle): penicillin, codeine, Anaesthetics, other:_____

Allergies (general), to:_____

_____

_____

Anything not listed above?_____

Has there been any problems with your general health in the past 5 years? ____Yes ____No

If yes, please explain_____

Are you presently under any physicians care? ____Yes ____No

If yes, please explain_____

Name of Physician:_____Phone# or city:_____

Are you presently taking any medications? (Please list)

_____

Do you smoke? ____ Yes ____No

Have you ever had any complications following dental treatment? ____Yes ____No

Do you have any health issues or problems that need further clarification, or anything else that you think the doctor should know about? ____Yes ____No

To the best of my knowledge, this information is complete and correct. If I ever have a change in my health, I will inform the doctors at the next dental appointment.

Signature of patient_____**Today's date**_____