Meadowlark Dental
• ASSOCIATES •

PATIENT INFORMATION

DATE: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

ADDRESS _____ HOME PHONE ( ) _____

CITY _____ STATE _____ ZIP _____ CELL PHONE ( ) _____

BIRTH DATE _____ SOCIAL SECURITY # _____ WORK PHONE ( ) _____

PATIENT/GUARANTOR DRIVER'S LICENSE # _____

☐ MALE ☐ FEMALE

EMAIL ADDRESS _____

PATIENT/GUARANTOR EMPLOYER _____ CITY/STATE _____

EMERGENCY CONTACT NAME _____ **EMERGENCY CONTACT PHONE #** _____

WHOM MAY WE THANK FOR INVITING YOU TO OUR OFFICE? _____

BILLING INFORMATION (IF DIFFERENT FROM ABOVE)

SPOUSE OR PARENT NAME RESPONSIBLE FOR ACCOUNT: _____

(CIRCLE ONE) ADDRESS _____

CITY/STATE/ZIP _____

BIRTH DATE _____ SOCIAL SECURITY # _____ EMPLOYER _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ WORK PHONE ( ) _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME & PHONE # _____

INSURANCE ID # _____ GROUP #_____

INSURED NAME _____ BIRTH DATE _____ SS # _____

SECONDARY INSURANCE COMPANY & PHONE # _____

INSURANCE ID # _____ GROUP # _____

INSURED NAME _____ BIRTH DATE _____ SS # _____

PLEASE PROVIDE DENTAL INSURANCE CARDS FOR OUR RECORDS

DENTAL HISTORY

REASON FOR TODAY'S VISIT _____

DATE OF LAST EXAM _____ DATE OF LAST X-RAYS _____

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU

- ☐ ARE YOU CURRENTLY EXPERIENCING ANY DENTAL PAIN OR DISCOMFORT
- ☐ DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING
- ☐ TEETH SENSITIVE TO HOT, COLD, SWEETS, OR PRESSURE
- ☐ LOOSE TEETH, CROWNS OR BROKEN FILLINGS
- ☐ ANY PROBLEMS WITH PREVIOUS DENTAL TREATMENT
- ☐ IS YOUR HOME WATER FLOURIDATED
- ☐ IS YOUR MOUTH DRY
- ☐ CONSISTENT BURING SENSATION IN THE MOUTH
- ☐ SORES OR ULCERS IN YOUR MOUTH
- ☐ DO YOU GRIND OR CLENCH YOUR TEETH
- ☐ HAVE HAD PERIODONTAL (GUM) TREATMENTS
- ☐ HAVE HAD ORTHODONTIC (BRACES) TREATMENT
- ☐ DO YOU WEAR DENTURES OR PARTIALS
- ☐ HAVE YOU HAD A SERIOUS INJURY TO YOUR HEAD OR MOUTH
- ☐ CLICKING, POPPING, PAINFUL JAW JOINTS

COMMENTS: _____

MEDICAL HISTORY

PHYSICIAN: _____ DATE OF LAST EXAM: _____

Has there been any change in your general health in the last year? ☐ YES ☐ NO

If yes please explain _____

Have you had a serious illness, operation, or have been hospitalized in the last 5 years? ☐ YES ☐ NO

If yes please explain _____

Have you had a total orthopedic joint replacement? ☐ YES ☐ NO

DATE COMPLETED_____

Are you required to take an antibiotic pre med before dental work? ☐ YES ☐ NO

Are you taking, have you taken or scheduled to take any antiresorptive bone mediactions for osteoporosis, Paget's Disease, bone pain, cancer therapy, or arthritis? (ex. Zometa, Aredia, XGEVA, Prolia, Boniva, Fosamax, Actonel, Reclast)

☐ YES ☐ NO

Do you have any of the following heart conditions? 1) Prosthetic Valve 2) Damaged Valve 3) Previous Infective Endocarditis 4) Congenital Heart Disease

☐ YES ☐ NO

WOMEN ONLY

Are you currently taking an oral contraceptive? ☐ YES ☐ NO

Are you expecting? Due Date _____ ☐ YES ☐ NO

Are you currently nursing? ☐ YES ☐ NO

MEDICATIONS: Please list any medications and the reason

_____

_____

_____

ALLERGIES

☐ LOCAL ANESTHETICS	☐ PENICILLIN	☐ PINE NUTS, PEANUTS	☐ GLUTEN
☐ ASPRIN	☐ BARBITURATES, SEDATIVES, SLEEPING PILLS	☐ SULFA DRUGS	☐ CODIENE, NARCOTICS
☐ METALS	☐ LATEX	☐ IODINE	☐ HAY FEVER, SEASONAL

OTHER _____

CHECK ANY THAT APPLY

☐ Cardiovascular Disease	☐ Rheumatic Fever	☐ Emphysema	☐ Stroke
☐ Angina	☐ Rheumatic Heart Disease	☐ Sinus Problems	☐ Glaucoma
☐ Arteriosclerosis	☐ Abnormal Bleeding/Bruising	☐ Tuberculosis	☐ Hepatitis, Jaundice, Liver Disease
☐ Congestive Heart Failure	☐ Anemia	☐ Cancer, Chemotherapy, Radiation Treatment	☐ Epilepsy
☐ Damaged Heart Valves	☐ Hemophilia	☐ Diabetes Type 1 or 2	☐ Fainting Spells or Seizures
☐ Heart Attack	☐ AIDS/HIV Infection	☐ Eating Disorder	☐ Sleeping Disorders
☐ Low Blood Pressure	☐ Arthritis	☐ Gastrointestinal Issues	☐ Snoring
☐ High Blood Pressure	☐ Autoimmune Disease	☐ Gastric Reflux, Persistent Heartburn	☐ Mental Health Disorders
☐ Mitral Valve Prolapse	☐ Rheumatoid Arthritis	☐ Ulcers	☐ Kidney Problems
☐ Pacemaker	☐ Asthma	☐ Thyroid Problems	☐ Osteoporosis
☐ Severe Headaches, Migranes	☐ Contact Lenses	☐ Recreational Drug Use	☐ Tobacco Use

OTHER:_____

SIGNATURE: _____ DATE: _____

Patient or Guardian

Patient Consent Form for Care & Treatment, HIPAA Authorization and Notification

By signing this authorization, I understand that my information will be disclosed for the following:

- I give my consent for any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposed or dental treatment for me or my dependent
- For general healthcare operations
- Appointment reminders and individuals involved in your care
- This authorization also gives permission to leave voicemails, send e-mails or text messages for appointment reminders and post-operative follow up

I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and records of any treatment or examinations rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Only the persons involved with my direct care are allowed access to my account information and/or medical condition(s) and treatment.

If I am unable to act on my own behalf, you may speak with the following person(s):

- Name: _____ Relationship to Patient: _____
- Name: _____ Relationship to Patient: _____

Signature of Patient/Legal Representative: _____

Date: _____

Additional HIPAA informational documents available upon request.