Patient History Form

Date _____

Name _____ Home Phone ( )_____
Last First Middle Pref. Name

Preferred Pronoun(s)/Nickname _____

Address _____ Business Phone ( ) _____
Number, Street

City _____ State _____ Zip Code _____ Cell Phone ( ) _____

Occupation _____ Employer _____ Social Security No. _____

Date of Birth _____/_____/_____ M F Height _____ Weight _____ Single _____ Married _____
Mo. Day Yr.

Name of Spouse _____If full time student, school name _____

Dental Ins. Co. _____ Group No. _____ E-mail _____

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

Person Responsible For Account

Please Check One ❑ Patient ❑ Father ❑ Husband
❑ Guardian ❑ Mother ❑ Wife ❑ Partner

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/ medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
❑ Adult Patient ❑ Father (Or Husband) ❑ Mother (Or Wife) ❑ Guardian

Service Charge

I understand that I am responsible for any charges incurred and unless other written arrangements are made, there will be 1 1/2% monthly service charge (which is an annual percentage rate of 18%). In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I authorize credit inquiries if I elect to obtain credit through arrangements with Meadow Place Dental.

_____
Date State Driver's License #

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Dental History Please Circle

Do you have a specific dental problem? Describe _____ YES NO
Do you have dental examinations on a routine basis? Last visit _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do you brush and floss on a routine basis? Please describe _____ YES NO
Do your gums ever bleed? Discuss _____ YES NO
How do you rate your smile on a scale of one to ten? _____ What would you like it to be? _____ YES NO
Past Orthodontic Treatment? _____ YES NO
Does food catch between your teeth? _____ Any loose teeth? _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? Do you wear a night guard? YES NO
Have your past experiences in a dental office always been positive? _____ YES NO
Any sores, growths, or abnormal tissue in your mouth? Any past biopsies? Please describe _____ YES NO
Date of last full mouth x-rays (16 small films or panoramic):_____
Date of last professional cleaning? _____
Name of previous dentist (optional): _____
Do you use any of the following:
❑ Cigarettes ❑ Cigars ❑ Chewing Tobacco ❑ CBD ❑ Medical Marijuana ❑ Vape _____
Do you snore or have apnea? _____ Do you wear a CPAP or Snore Guard? _____