MEADOWS DENTAL GROUP
HEALTH HISTORY AND REGISTRATION

ALLERGY
1 2 3 4 5 6 7

PREMEDICATION
Antibiotics: _____

Patient Name Last _____ First _____ Middle Initial _____ Nickname _____
Residence Street _____ City _____ State _____ Zip _____ How Long? _____
Mailing Address Street _____ City _____ State _____ Zip _____
Previous Address (if less than 3 yrs.) _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell/Pager _____
Social Security _____ Driver's License # _____ Today's Date _____
Employer _____ Occupation _____ No. Years Employed _____
Sex: M F Birth Date _____ Age? _____ Married Y / N E-mail _____
Reason for today's visit _____ Last Dental Visit _____ **Whom may we thank for referring you to our office?** _____
Student Status _____ School _____ City _____ State _____ Zip _____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name Last _____ First _____ Middle _____ Marital Status _____
Residence Street _____ City _____ State _____ Zip _____ How Long? _____
Mailing Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Birth Date _____
Social Security # _____ Driver's License _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

DENTAL INSURANCE (PRIMARY CARRIER)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Social Security # _____
Group _____ Phone # _____

SECONDARY (COMPLETE IF YOU HAVE DOUBLE INSURANCE COVERAGE)

Insured's Name _____
Insurance Co. _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Social Security # _____
Group _____ Phone # _____

MEDICAL HISTORY

We need to know about your Medical and Dental History: This information is confidential. Thank you for taking the time to fill out this questionnaire.

Circle if you have or have had the following: Heart Attack or Heart Disease / Angina / Murmur / Congenital Heart Lesions / Mitral Valve Prolapse
Rheumatic Fever / High Blood Pressure / Artificial Valve / Pacemaker / Heart Surgery / Artificial Joints
Diabetes / Anemia / Hemophilia / Bleeding Problems / Blood transfusions / Ulcers / Kidney Problems / Hepatitis A or B or C / Liver Disease
Thyroid disease / Glaucoma / Epilepsy / Seizures / Stroke / Tuberculosis (TB) / Asthma / Hayfever / Sinusitis / Chemotherapy
Radiation Therapy / Arthritis / Cortisone Therapy / Alcoholism / Drug Addiction / Psychiatric Treatment / A.I.D.S. / A.R.C. / HIV Pos.

Are you allergic to or have you had any problems with the following?
Penicillin / Erythromycin / Codeine / Aspirin / Motrin or Advil / Local Anesthetic / Nitrous Oxide Do you smoke or chew tobacco? Y N
If Yes, Describe Problem _____
Allergy to other medications or anything else we should know about? _____
Medications? _____ Are you pregnant? _____
Family Physician _____ Phone # _____
Last Complete Dental Exam _____ X-Rays _____ Previous Dentist _____

Circle if you have or have had:
Braces / Gum Treatments or Bleeding Gums / Problem with Jaws / Head, Neck, Pain in the Jaw / Fever Blisters / Sensitive Teeth
Grinding / Clenching / Discolored Teeth / Dentures / Partials / Bleaching / Bonding / Cosmetic Dentistry / Cosmetic Head or Neck surgery

The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and th erapy that may be indicated. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any over due balance. If legal action becomes necessary to collect fees due the office, the undersigned, agrees to pay all reasonable costs of such action including attorney's fees and collection costs and interest of 1.5% per month (18% per annum) on the unpaid balance 60 days from the treatment. I understand that credit reports are obtained.

Patient Signature (Consent) _____ Date _____ Dr.'s Signature _____

Please fill out other side

MEADOWS
DENTAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

Thank you for choosing Meadows Dental Group for your dental care needs. The following information will explain our procedures and policies, which have been established so that we may serve you as promptly and efficiently as possible. Financial arrangements must be made prior to treatment.

- Payment is due in full at the time of service for patients without dental insurance. Patients with insurance coverage are responsible for any deductibles and estimated co-payments at the time of service.
- Third party financing is available for patients requiring extensive treatment ($300 or more with approved credit). See our Treatment Coordinator for more details on the Care Credit program.
- In the event you would like to pay up front at the time of service in cash/guaranteed funds, we would not process a credit inquiry. However, when we bill insurance and accept assignment of future insurance and patient payments, we do reserve the right to run a brief credit inquiry in order to establish a history with the patient.
- **A 24 hour notice is required to reschedule/cancel an appointment or a $75.00 fee will be applied.**

A word about Dental Insurance-
As a service to our patients we will bill your insurance company. However, your insurance policy is a contract between you and your insurance company. You are responsible for any fees insurance does not pay. The remaining balance is the responsibility of the patient. Please refer to your employee manual for specific coverage explanations. **If your insurance has not paid within 60 days we ask you to clear the balance within 15 days.**

If you have any questions regarding treatment, fees or services, please feel free to discuss them with us at any time. Provisions and policies contained in this agreement may change without prior written notice.

I understand and agree to abide by this Financial Policy.

_____ _____

Signature of patient/responsible party Date