Meridian Periodontics & Dental Implants Patient Registration

Please Print Legibly

DATE:	***PATIENT INFORMATION***				
Last Name:	First:	Middle:	❑ Dr. ❑ Mrs.	❑ Mr. ❑ Ms.	Marital status (circle one): Single / Mar / Div / Sep Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security #:	Main phone #: ( )

P.O. Box:	City:	State:	ZIP code:

Occupation:	Employer:	Employer phone #: ( )

How did you hear about our office?

❑ Dr. _____ ❑ Insurance plan ❑ Family

❑ Other _____ ❑ Friend ❑ Internet search

INSURANCE INFORMATION

DO YOU CURRENTLY HAVE DENTAL INSURANCE? Y☐ N☐ If YES, please fill-out section below and give your insurance card to one of the Treatment Coordinators. If NO, please skip to the next section.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

PRIMARY DENTAL INSURANCE COMPANY:

Primary Subscriber's Name: **DOB:** / / **SSN:**

Group #: **Insurance Phone #:**

SECONDARY DENTAL INSURANCE COMPANY:

Group #: **Insurance Phone #:**

Primary Subscriber's Name: **DOB:** / / **SSN:**

IN CASE OF AN EMERGENCY

Name of local friend or relative:	Relationship to patient:	Main phone #: ( )	Additional phone #: ( )

The above information is correct to the best of my knowledge. I understand that I am financially responsible for the payment of treatment completed.

_____

Patient's or guardian's signature

Patient's Name: _____ Date: _____

Health History Form

Female patients, please answer the following:

Y N
☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant or plan on becoming pregnant? If pregnant, # of weeks _____
☐ ☐ Are you nursing?

All patients, please answer the following:

Y N
☐ ☐ Do you use tobacco or marijuana related substances?
If Yes: How many per day _____ How long? _____

Weight: _____
Height: _____

Y	N	Conditions/Medical Treatments	Y	N	Conditions/Medical Treatments	Y	N	Conditions/Medical Treatments
☐	☐	Abnormal Bleeding	☐	☐	Glaucoma	☐	☐	Sickle Cell Disease
☐	☐	Angina Pectoris	☐	☐	Heart Attack/Stroke	☐	☐	Sinus Problems
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Sleep Apnea
☐	☐	Arthritis: Osteoarthritis	☐	☐	Hepatitis: ☐ A ☐ B ☐ C	☐	☐	Sjogren's Syndrome
☐	☐	Arthritis: Rheumatoid	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems (Hyper/Hypo)
☐	☐	Artificial Heart Valve	☐	☐	High Cholesterol	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	History of Bisphosphonate Medications	☐	☐	Ulcers
☐	☐	Benign Tumor or Growth	☐	☐	HIV / AIDS	☐	☐	Xerostomia (Dry Mouth)
☐	☐	Blood Transfusion	☐	☐	Joint Replacement	**Y**	**N**	**Allergic to the Following:**
☐	☐	Bruxism (Jaw Grinding/Clenching)	☐	☐	Kidney Problems	☐	☐	Aspirin
☐	☐	Cancer Type:	☐	☐	Liver Disease	☐	☐	Codeine
☐	☐	Chemotherapy	☐	☐	Low Blood Pressure	☐	☐	Dental Anesthetics
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Erythromycin
☐	☐	Cosmetic Surgery	☐	☐	Osteoporosis	☐	☐	Latex
☐	☐	Diabetes: ☐ Type 1 ☐ Type 2	☐	☐	Pacemaker	☐	☐	Metals
☐	☐	Difficulty Breathing	☐	☐	Parkinson's Disease	☐	☐	Penicillin
☐	☐	Drug Abuse	☐	☐	Prostate Problems	☐	☐	Tetracycline
☐	☐	Epilepsy / Seizures	☐	☐	Psychiatric Problems	☐	☐	Other:
☐	☐	Fainting	☐	☐	Radiation Therapy	**Y**	**N**	**Premedication Required**
☐	☐	Fever Blisters	☐	☐	Rheumatic Fever	☐	☐	Amoxicillin
☐	☐	Fibromyalgia	☐	☐	Sexually Transmitted Infection	☐	☐	Clindamycin
☐	☐	Frequent Headaches	☐	☐	Seasonal Allergies	☐	☐	Other:
☐	☐	GERD (Acid Reflux)	☐	☐	Shingles			

PLEASE LIST ALL CURRENT MEDICATIONS / PREMEDICATIONS:

_____
_____
_____
_____

Is there any medical condition that you think this office should know about that is not mentioned above? If yes, please describe.

Have you ever suffered any serious injury to your mouth or head? If yes, please describe.

Please describe your main concern that prompted your visit with us.

Please describe any past dental surgeries.

Y	N		Y	N	Have you ever had:
☐	☐	Teeth sensitive to hot or cold?	☐	☐	Orthodontic treatment (braces)
☐	☐	Teeth sensitive to sweets?	☐	☐	Oral surgery (jaw surgery, dental implants)
☐	☐	Teeth sensitive on biting or chewing?	☐	☐	Periodontal treatment (bone grafting, gum grafting, laser)
☐	☐	Have you noticed foul odors or bad taste from your mouth?	☐	☐	A bite guard or mouth guard
☐	☐	Do you frequently get cold sores, blisters, or ulcers?	☐	☐	Clicking or popping of the jaw
☐	☐	Do your gums bleed or hurt?	☐	☐	Clenching or grinding teeth while awake or asleep
☐	☐	Does food tend to become caught in between your teeth?	☐	☐	Difficulty in chewing on either side of the mouth
☐	☐	Have your parents experienced gum disease or tooth loss?	☐	☐	Headaches, neck aches or shoulder aches
☐	☐	Have you noticed any loose teeth or changes in your bite?	☐	☐	Snoring or any other sleeping disorders

Physician's Name:	Physician's Phone #

Pharmacy:	Pharmacy Phone #

I acknowledge that the information above is correct to the best of my knowledge and consent to allow the office to share medical information with the insurance company to help support medical necessity for my procedures.

Patient's Name Printed: _____

Patient's or Guardian's Signature: _____

Date: _____

Meridian Periodontics & Dental Implants
HIPAA & Medical Information Release

Your permission and acknowledgement are necessary for us to:

- RELEASE MEDICAL INFORMATION TO YOUR INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF ALL INSURANCE CLAIMS
- RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY FOR YOUR TREATMENT
- ENSURE PAYMENT FOR SERVICES RENDERED

I hereby authorize the release of all medical/dental information necessary to process my insurance claims. I authorize the release of this same information, when necessary, to other providers rendering medical/dental care, as well as to laboratories that need my information to plan procedures or fabricate an appliance necessary for my treatment.

Please list any additional person(s) involved in your care (family member(s), significant other(s), children, caregiver(s), etc.) with which we may share your medical and dental information:

_____

_____

Any limitations or special instructions:

_____

_____

*Patient's Name Printed:*_____

Patient's or Guardian's Signature: _____

Date: _____