Meridian Dental associates

1650 Main Street, South Weymouth, MA 02190

Thank you for choosing Meridian Dental Associates to be your oral health provider and congratulations on taking the first step to better dental health. Our goal is to provide you with dental care in a comfortable and friendly environment.

PATIENT INFORMATION

Date: _____ ( )NEW PATIENT ( )UPDATE

Patient Name: _____
LAST FIRST MI PREFERRED TITLE

( )MALE ( )FEMALE ( )CHILD* ( )STUDENT** ( )SINGLE ( )MARRIED ( )DIVORCED ( )WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S)BELOW:	**IF STUDENT, PLEASE COMPLETE: ( )FULL-TIME ( )PART-TIME
_____ PARENT/GUARDIAN NAME(S)	_____ SCHOOL/LOCA TION

Patient Date of Birth:_____ Patient SSN:_____

Address:_____ Home Phone: _____

_____ Cell: _____

_____ Other: _____
City State Zip code

E-Mail:_____

Referral? ( ) Yes ( )No Referred by:_____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person:

_____Tel:_____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____

_____ Work Phone: _____x_____

_____ Direct: _____
City State Zip code

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth:_____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ( )SELF ( )SPOUSE ( )CHILD ( )OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ID No.: _____

Address:_____ TEL: _____

_____FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.:_____ ID No.: _____

Address: _____TEL: _____

_____FAX: _____

PREVIOUS DENTIST INFORMATION

Dentist: _____Telephone: _____

Address: _____

_____

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ( )EXCELLENT ( )GOOD ( )FAIR ( )POOR

Date of Last Dental Visit: _____Treatment Type: _____

( )Y ( )N Are you currently having dental discomfort? If yes, explain: _____

( )Y ( )N Any unhappy/unpleasant dental experiences? If yes, explain: _____

( )Y ( )N Any injuries to mouth/teeth/head? If yes, explain: _____

( )Y ( )N Any missing teeth other than wisdom teeth or orthodontic extractions? Have missing teeth been replaced? ( )Y ( )N

( )Y ( )N Orthodontic appliances now or in the past?

( )Y ( )N Gums bleed when brushing or flossing?
( )Y ( )N Concerned about gum disease? History of gum disease? ( )Y ( )N
( )Y ( )N Any concerns about the appearance of your teeth?
( )Y ( )N Does it hurt to bite or chew?
( )Y ( )N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ( )Y ( )N
( )Y ( )N Have you ever had any difficult extractions in the past? Have you ever had any prolonged bleeding following extraction? ( )Y ( )N
( )Y ( )N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:_____
What factors are most important for your satisfaction with our office? _____
Any additional concerns/comments?_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:
( )Y ( )N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
_____
( )Y ( )N An unusual speech habits? If yes, explain: _____
( )Y ( )N Any lost teeth? If yes, list: _____
( )Y ( )N Does the patient receive assistance with brushing and flossing? If yes, how often?
_____

MEDICAL HISTORY

Primary Physician's Name: _____ Telephone: _____
Address: _____
Last Physical Exam: _____
GENERAL HEALTH: ( )EXCELLENT ( )GOOD ( )FAIR ( )POOR
( )Y ( )N Under a physician's care now?
( )Y ( )N Any hospitalization in the past 5 years?_____
( )Y ( )N Any serious illnesses/surgeries? _____
( )Y ( )N Use tobacco in any form? If Yes, Type: _____
( )Y ( )N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ( )Y ( )N Currently nursing? ( )Y ( )N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ( )Y ( )N
If yes, please describe:_____
Is there anything important about your medical condition we have not asked? ( )Y ( )N If yes, please describe:
DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ( )NONE

( ) Acid reflux	( ) Cancer/Malignancy	( ) Hay fever	( ) Pacemaker
( ) ADHD	( ) Chemical dependency	( ) Hearing problems	( ) Parathyroid condition
( ) AIDS/HIV	( ) Chicken pox	( ) Heart attack	( ) Psychiatric treatment
( ) Anemia	( ) Convulsions	( ) Heart disease	( ) Radiation/Chemo
( ) Anorexia	( ) Congenital heart disease	( ) Heart murmur	( ) Respiratory disease
( ) Anxiety	( ) Depression	( ) Hepatitis	( ) Rheumatic/Scarlet fever
( ) Artificial heart valve	( ) Diabetes	( ) High/Low blood pressure	( ) Sinus problems
( ) Artificial joints	( ) Dizziness/Fainting	( ) High cholesterol	( ) Sickle cell disease
( ) Arthritis/Gout	( ) Epilepsy/Seizures	( ) Hives/Rash	( ) Shingles
( ) Asthma	( ) Frequent ear infections	( ) Irregular heart beat	( ) Stroke
( ) Autism/Asperger's	( ) Frequent headaches	( ) Kidney disease	( ) Thyroid condition
( ) Bleeding disorder	( ) Frequent cough	( ) Liver disease	( ) Tuberculosis
( ) Blood transfusions	( ) Frequent Diarrhea	( ) Mitral valve prolapse	( ) Ulcers/Colitis
( ) Bulimia	( ) Fever blisters/Herpes	( ) Mononucleosis	( ) Venereal disease
( ) Bruise easily	( ) Glaucoma	( ) Osteoporosis	( ) Other-Please list:

ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ( )NONE

( ) Acrylic	( ) Codeine	( ) Metal	( ) Penicillin
( ) Aspirin	( ) Dairy	( ) Nitrous oxide	( ) Other antibiotics
( ) Anesthetic-local	( ) Latex	( ) Sleeping pills	( ) Other-Please list:
( ) Barbiturates	( ) Lactose intolerance	( ) Sulfa drugs	

MEDICATION INFORMATION

Do you take or have you taken Phen-Fen or Redux? ( )Y ( )N
Have you ever taken Fosamex, Bonivia, Actonel or any other medications containing bisphosphonates? ( )Y ( )N

Are you currently taking any prescription or daily OTC medications including, but not limited to any of the following? (Check all that apply): ( )NONE

( ) Antibiotics/Sulfa drugs	( ) Antihistamines/Allergy	( ) Daily Aspirin	( ) Blood pressure meds
( ) Blood thinners	( ) Cancer/Chemo meds	( ) Cortisone/Steroids	( ) Heart meds/Digitalis
( ) Insulin	( ) Nitroglycerin	( ) Oral contraceptives	( ) Osteoporosis meds
( ) Other Diabetic medications	( ) Recreational drugs	( ) Thyroid medications	( ) Tranquilizers
			( ) Other-Please list

*Patients on **BIRTH CONTROL PILLS** must aware that antibiotics (and some other medications) may interfere with the effectiveness of birth control pills. Therefore, please consult with your physician regarding other methods of birth control.*

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status and/or if my medication changes, I shall inform the dentist and staff at the next appointment without fail. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature of Patient or Personal Representative: _____Date:_____

If personal representative, relationship to patient: _____ Doctor's initials: _____