MEADOW DENTAL CENTER

Name _____ DOB _____ Gender_____
Street _____ City_____ State____ ZIP_____
Phone_____ Social Security Number _____

Dental Insurance Company_____ Member ID _____
*Please provide the front desk with your insurance card
Emergency Contact Name _____ Phone _____
Are you under the care of a physician? Y/N Physician Name_____
Are you currently taking any medications? Y/N
If yes, please list _____
Do you have any allergies? Y/N
If yes, please list _____
Have you ever been hospitalized? Y/N
If yes, please explain _____
Have you ever had an injury to your head or neck? Y/N
If yes, please explain _____
For women, are you currently pregnant or nursing? **Y/N**
Do you wish to speak to the dentist privately about anything? **Y/N**
Do you snore? **Y/N** Do you feel rested in the morning? **Y/N**
Do you use tobacco products? **Y/N**
Do you have any concerns such as sensitivity, painful/bleeding gums, sore jaw, etc.? **Y/N**
If yes, please explain _____
Do you like your smile? **Y/N**
If no, please explain_____
Who can we thank for referring you to our office? _____
Please circle any condition that apply to you:

***Alzheimer's *AIDS *Autism *Asthma *Anemia *Arthritis/Gout**
***Artificial Joint *Artificial Valve *Allergies *Blood Disorder**
***Blood Transfusions *Bruise Easily *Breathing Problems *Cancer**
***Chemotherapy/Radiation *Chest Pain *Cold Sores*Drug Addiction**
***Diabetes *Eating Disorder *Emphysema *Epilepsy/Seizures**
***Fainting/Dizziness *Glaucoma *Heart Condition *Hepatitis**
***High/Low Blood Pressure *High/Low Blood Sugar *HIV *Hives**
***Irregular Heartbeat *Liver Condition *Lung Condition *Osteoporosis *Psychiatric Care *Pacemaker *Rheumatic Fever *Stroke *Stomach Condition *Sickle Cell**
***Scarlet Fever *Thyroid Condition *Tuberculosis *Tumors/Growths *Ulcers**

Please include any conditions that were not listed above _____

I have read everything on this form and have answered to the best of my knowledge.
SIGNATURE_____DATE_____