Meader Family Dentistry
5505 Indian River Road, Suite 200 • Virginia Beach, Virginia 23464
(757) 424-1300 • FAX (757) 424-0219

PATIENT INFORMATION FORM

Name_____ Sex_____ Date Of Birth_____
Address_____ City_____ State_____ Zip_____
Phone_____ Cell #_____ Work#_____
Email_____ Social Security#_____
Employer_____ Title_____ How long?_____
Spouse's/ Partner Name _____ Phone #_____
Spouse's Employer _____ Title _____ How long?_____
Emergency Contact:
Name_____ Phone#_____
How did you hear about our office? _____
Referred by? _____

INSURANCE INFORMATION

Plan Name _____
Address_____
Phone#_____ Group#_____
ID#_____ Insured SSN#_____
Insured Name_____ Insured DOB_____

PLEASE READ AND INITIAL

If you are taking birth control pills, please be advised that some studies have shown them to be less effective or ineffective while taking certain antibiotics. Therefore, you should take necessary precautions if this applies to you. ___

In the case of accidental exposure to any body fluids, I as well as the health care worker, agree to be tested for any infectious diseases which may be transmitted through this exposure. (state law) ___

Recent evidence has surfaced that life-threatening results can occur from the interaction of non-prescription drugs, such as cocaine, with the local anesthesia administered in dental treatment. If you are taking ANY medication, prescribed or non-prescribed, it is ESSENTIAL that you inform the dentist prior to treatment. ___

AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I have authorized the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I hereby consent to treatment and realize that I am fully responsible for the fees related to this treatment. A 12% finance charge will be applied to balance over 60 days past due. In the event my account is in default and is referred to an attorney for collections. I agree to pay attorney's fees of 33 1/3% of the unpaid balance at time of referral.

Signature of Patient of Parent/Guardian:_____ Date:_____

DENTAL HISTORY

Reason for visit _____

Do you have problems with any of the following :

__Bad Breath __Food Collection between teeth __ Periodontal Treatment __Sensitivity to sweets __Bleeding Gums
__Grinding or clenching teeth __Sensitivity to cold/hot __clicking or popping jaw __loose teeth or broken filling
__sores of growths in mouth

How often do you brush? _____ How do you feel about the appearance of your teeth?

_____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
__ yes __ no

MEDICAL HEALTH HISTORY

Are your currently under physician care? __ yes __ no If yes, describe _____

Your physician's name _____ Phone# _____

Are you pregnant? __ yes __ no Nursing? __ yes __ no Taking birth control pills? __ yes __ no

Do you smoke, vape or use tobacco? __ yes __ no

Are you required to Pre-Medicate before any dental treatment? __ yes __ no

Do you have, or have you had any of the following ? (Please check any that apply):

__ AIDS/HIV Positive
__Anaphylaxis
__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Atopic (Allergy Prone)
__Back Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough, Persistent
__Cough up blood
__Diabetes
__Epilepsy
__Fainting
__Food Allergies
__Glaucoma
__Headaches
__Heart Murmur
__Heart Problems
Describe_____
__Hemophilia/Abnormal Bleeding
__Herpes
__Hepatitis
__High Blood Pressure
__Jaw Pain
__Kidney Disease or Malfunction
__Liver Disease
__Material Allergies (Latex, Wool, Metal, Chemicals)
__Mitral Valve Prolapse
__Nervous Problems
__Pacemaker/Heart Surgery
__Psychiatric Care
__Rapid Weight Gain/Loss
__Radiation Treatment
__Respiratory Disease
__Rheumatic/Scarlet Fever
__Shingles
__Shortness of Breath
__Skin Rash
__Spina Bifida
__Stroke
__Surgical Implant
__Swelling of Feet/Ankles
__Thyroid Disease/Malfunction
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Ulcer/Colitis
__Venereal Disease
__Other_____

LIST OF MEDICATIONS:_____

_____

LIST OF DRUG ALLERGIES, IF ANY:_____

_____

PATIENT'S SIGNATURE: _____ DATE: _____ STAFF: _____