# Welcome!

We would like to welcome you to Meister Dental Group. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime.

## 1 Patient Information

Today's Date _____

First Name: _____ MI_____

Last Name: _____

Birthdate _____ Age_____ SS#_____

__Single __Married __Divorced __Widowed __Child

Address _____

_____

Home # _____ Cell #_____

Work #_____ Extension # _____

Email _____

**How did you hear about our practice?** _____

**In case of emergency:**

Emergency Contact Name_____

Emergency Contact Phone # _____

## 2 Employment Information

Employer Name_____

Occupation _____

Work Address _____

_____

## 3 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan Name _____ Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS#_____

Policy Owner's Employer _____

Employee's Address _____

_____

## 4 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Plan Name: _____ Group #: _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ SS#_____

Policy Owner's Employee _____

Employee's Address _____

_____

## 5 Dental History

Purpose of today's visit _____

Date of last cleaning _____

Date of last X-Rays _____

How often do you brush? _____

**Any:**

___Sensitive Teeth ___Jaw Pain
___Loose Teeth ___Injuries to Teeth
___Broken Teeth ___Bleeding Gums

**Have you had unpleasant dental experiences in the past?**

Yes___ No___

Explain _____

**Have you ever had:**

___Crowns
___Veneers ___Implants
___Root Canals ___Gum Treatment
___Oral Surgery ___Orthodontic Treatment

**Have you ever done teeth whitening?** Yes___ No___

___ In Office ___Overnight ___Purchased

**Are you interested in replacing any missing teeth?** Yes___ No___

**Which method:** ___With Dentures ___Bridges ___Implants

**Do you have any questions for the dentist?** Yes___ No___

Explain: _____

## 6 Medical History

Physician Name: _____

Office Address: _____

_____

Telephone #: _____

**Are you currently under the care of a physician?** Yes__ No__

Explain _____

**Has there been a recent change in your health?** Yes__ No__

Explain _____

**Are you currently taking any prescription, over the counter or recreational drugs?** Yes ___ No ___

Please list: _____

_____

_____

_____

**Have you been hospitalized or had a serious illness within the past five years?** Yes ___ No ___

Explain _____

**Have you been treated now or in past with Bisphosphonates for Osteoporosis or cancer?** Yes ___ No ___

Explain _____

**Are you pregnant or is it likely that you could be pregnant at this time?** Yes ___ No___ If so, how far along? _____

**Circle Y/N if you have or ever had:**

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Artificial Limb/Joint/Hip | Y | N | High Cholesterol |
| | | When? _____ | Y | N | Hyperthyroidism |
| Y | N | Artificial Heart Valve | Y | N | Hypothyroidism |
| Y | N | Acid Reflux | Y | N | Hepatitis: A / B / C |
| Y | N | Arthritis | Y | N | Heart Disease |
| Y | N | Anemia | | | Explain: _____ |
| Y | N | Asthma | Y | N | Joint Surgery |
| Y | N | Angina | Y | N | Kidney Problems |
| Y | N | Addictions | Y | N | Low Blood Pressure |
| | | Type: _____ | Y | N | Migraines |
| Y | N | Aspirin Daily | Y | N | Mitral Valve Prolapse |
| Y | N | Blood Disorder | Y | N | Mouth Ulcers |
| | | Type: _____ | Y | N | Organ Transplant |
| Y | N | Bells Palsy | Y | N | Prolonged Bleeding |
| Y | N | Chronic Diarrhea | Y | N | Psychiatric Care |
| Y | N | Cancer | Y | N | Pacemaker |
| | | Type: _____ | Y | N | Rheumatic Fever |
| Y | N | Dizziness/Fainting | Y | N | Radiation Therapy |
| Y | N | Diabetes | Y | N | Recurrent Infections |
| | | Type I: ____Type II: ____ | Y | N | Sinus Problems |
| Y | N | Epilepsy/Seizures | Y | N | Shortness of Breath |
| Y | N | Emphysema | Y | N | Stroke / TIA Date: _____ |
| Y | N | Frequent Urination | Y | N | STD - Type: _____ |
| Y | N | Glaucoma | Y | N | Treated for AIDS/HIV |
| Y | N | High Blood Pressure | Y | N | Tuberculosis |
| Y | N | Hay Fever | Y | N | Trigeminal Neuralgia |
| Y | N | Head Injury | Y | N | Ulcers/Colitis |
| Y | N | Heart Murmur | Y | N | Unexplained Weight Loss |

**Do you?**

___ Take Blood Thinners? If so, Type: _____

___ Smoke?

Packs per day?_____ How long?_____

Do you have a history of smoking? Yes ___ No ___

If so, how long? _____

___Chew Tobacco

Please mark any allergies/adverse reactions :

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Penicillin | Y | N | Aspirin |
| Y | N | Tetracycline | Y | N | Valium |
| Y | N | Clindamycin | Y | N | Barbiturates |
| Y | N | Keflex | Y | N | Latex |
| Y | N | Local Anesthetics | Y | N | Iodine |
| Y | N | Codeine | Y | N | Household Bleach |
| Y | N | NSAID (Advil/Motrin) | | | |
| Y | N | Gluten | Other _____ | | |

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with _____. I understand that using anesthetic agents embodies a certain

(NAME OF PATIENT)

risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistance as deemed to provide recommended treatment.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Dentist Signature Date

# Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full co-payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ At Meister Dental Group we schedule your appointment so that the time is reserved for you. We do not double book our patients; therefore, we reserve the right to charge $50.00 per broken appointment without the required notice of cancellation. This fee will be charged to compensate for the amount of time the doctor has spent in planning your treatment and the amount of time allotted for your appointment.

_____ If your appointment must be rescheduled or canceled, we require that you notify us 24 hours before your scheduled appointment. Please notice that each case is different and that the required amount of time may vary. Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact.

_____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

**Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:
***Interest charges of 1.5% per month***
***18% APR collections fees (up to 25% of the full balance)***
***Legal fees for collection services***

_____ _____
Signature of Patient or Guardian Date

_____
Print Name