Print Name _____ Date _____

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Welcome to Our Practice!

Thank you for trusting us to provide your dental care!

Whom may we thank for referring you to our office? _____

Guest Information

Completed patient information ensures your safety in case of emergency. It also allows us to extend the courtesy of alerting you to unexpected schedule openings and of processing your insurance claims. Thank you!

Last Name _____ First Name _____

Middle _____ Preferred Name _____ Title _____ Marital Status _____

Birth Date _____/_____/_____ Social Security _____-_____-_____

Street Address _____

City _____ State _____ Zip Code _____

E-Mail _____ Home Phone _____-_____-_____

Cell Phone _____-_____-_____ Work Phone _____-_____-_____

Employer _____

Employment Address _____

Emergency Contact _____ Phone _____-_____-_____

Relationship to Patient _____

Responsible Party Information if Different From Above

Last Name _____ First Name _____

Middle _____ Relationship to Patient _____

Social Security _____-_____-_____ Birth Date _____/_____/_____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____-_____-_____ Work Phone _____-_____-_____

Occupation _____ Employer _____

Employment Address _____

Insurance Information

Insured's Last Name_____ **First Name**_____

Is insured a patient? Yes No **Insured's Relationship to Patient** _____

Insured's Social Security #_____-_____-_____ **Insured's Birth Date** _____

Insurance Company _____ **Group Number** _____

Insurance Company Address _____

Insurance Company Phone _____-_____-_____ **Insured's Employer**_____

Employment Address_____ **Work Phone** _____-_____-_____

If you have dual coverage, please complete the following secondary insurance information.

Insured's Last Name _____ First Name _____

Is insured a patient? Yes No Insured's Relationship to Patient _____

Insured's Social Security #_____-_____-_____ Insured's Birth Date _____

Insurance Company _____ Group Number _____

Insurance Company Address _____-_____

Insurance Company Phone _____-_____-_____ Insured's Employer _____

Employment Address _____ Work Phone _____-_____-_____

Medical Information

Physician's Name _____ Date of Last Exam (if known) _____

Physician's Address _____ Physician's Phone _____-_____-_____

Have you recently been under your physician's care for a specific condition? Yes No

If yes, please specify. _____

Please list all your medications or drugs, including prescription medications, over the counter medications, herbal or holistic remedies, vitamins minerals, etc. _____

_____

Please list any medication or anesthetics to which you are allergic. _____

Do you need to **pre-medicate** prior to dental treatment for the following reasons: history of infective endocarditis, artificial heart valves or valve repair, congenital heart disease, or cardiac transplantation?
Yes No

Do you smoke cigarettes or chew tobacco? Yes No

Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	Yes	No	Cancer	Yes	No	Hives	Yes	No
Heart Disease or Attack	Yes	No	Radiation Therapy	Yes	No	Easy Bruising	Yes	No
Angina Pectoris	Yes	No	Chemotherapy	Yes	No	Yellow Jaundice	Yes	No
Congenital Heart Disease	Yes	No	Emphysema	Yes	No	Epilepsy or Seizures	Yes	No
Heart Murmur	Yes	No	Chronic Cough	Yes	No	Lyme	Yes	No
High Blood Pressure	Yes	No	Tuberculosis	Yes	No	Nervousness	Yes	No
Arteriosclerosis	Yes	No	Tumors	Yes	No	Anorexia/Bulimia	Yes	No
Mitral Valve Prolapse	Yes	No	Asthma	Yes	No	Bleeding Gums Brushing Teeth	Y	N
Artificial Heart Valve	Yes	No	Sinus Trouble	Yes	No	Ringing/Buzzing in Ear	Yes	No
Heart Pacemaker	Yes	No	Hay Fever	Yes	No	Loss of Hearing	Yes	No
Heart Surgery	Yes	No	Respiratory Problems	Yes	No	Fainting or Dizzy Spells	Yes	No
Stroke	Yes	No	Seasonal Allergies	Yes	No	Whiplash Injury	Yes	No
Rheumatic Fever	Yes	No	Latex Allergy	Yes	No	Headaches	Yes	No
Anemia	Yes	No	Codeine Allergy	Yes	No	Chronic Facial Pain	Yes	No
Arthritis	Yes	No	Penicillin Allergy	Yes	No	Pain in Jaw Joint	Yes	No
Rheumatism	Yes	No	Sulfa Allergy	Yes	No	Clicking, Popping Jaw	Yes	No
Cortisone Medication	Yes	No	Hepatitis A (infectious)	Yes	No	Locking Jaw	Yes	No
Artificial Joints (hip, etc.)	Yes	No	Hepatitis B (serum)	Yes	No	Tired Jaw After Sleep	Yes	No
Liver Disease	Yes	No	Hepatitis C	Yes	No	Tired Jaw After Meal	Yes	No
Kidney Trouble	Yes	No	Venereal Disease	Yes	No	Difficulty Opening Wide	Yes	No
Diabetes	Yes	No	Cold Sores/Fever Blisters	Yes	No	Teeth Clenching	Yes	No
Ulcers	Yes	No	Blood Transfusion	Yes	No	Teeth Grinding at Night	Yes	No
Thyroid Problems	Yes	No	Hemophilia	Yes	No	Snoring	Yes	No
Glaucoma	Yes	No	Sickle Cell Disease	Yes	No	Chronic Stuffed Nose	Yes	No

Do you have or have you had any disease, condition or problem not listed above? Yes No

If yes, please identify: _____

Do you have any disease, are you taking any medication/drugs, or have you had any transplant operation that has or may have depressed your immune system? Yes No

Do you have a history of alcohol / chemical dependency / emotional disorder / developmental disability that may have an impact on your needs or on the care we provide you? Yes No

Do you wish to speak with the doctor privately about anything? Yes No

For Women: Are you pregnant? Yes No Due date_____
Are you nursing? Yes No Are you taking birth control pills?* Yes No

* If you are using non-mechanical contraceptives, antibiotics *may* interfere with their effectiveness. Consult your physician; you may wish to use mechanical forms of birth control for one full cycle after completion of antibiotic treatment.

Dental Information

Do you fear dental work? Yes No

What brings you to your first visit with Meetinghouse Dental Care? _____

_____

Ideally, is there *anything* you wish to change about the appearance of your smile (discolored, crooked, crowded teeth, fillings, gaps, missing teeth, too small or too large teeth, gummy smile, etc.)? We want to know!

_____

Consent

- I understand that the above information is necessary for the doctors to provide me with comprehensive dental care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.
- I authorize the doctors of Meetinghouse Dental Care to take radiographs and photographs, make study models, or employ other diagnostic aids deemed appropriate by them for the purpose of making a thorough diagnosis of my dental needs.
- I authorize the doctors of Meetinghouse Dental Care to perform all recommended treatment with which I have agreed and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.
- I authorize the release of examination findings, diagnosis, treatment program, etc. to my referring or treating dental specialists and/or physicians.
- I understand that all responsibility for payment for dental services provided in this office for myself and/or for my dependents is mine, payable at the time services are rendered unless other arrangements have been made.
- If I have dental insurance, I realize that my insurance coverage represents a contract between my insurance company and me and that said coverage depends upon the plan that I have chosen or that the insured's place of employment has purchased on my behalf. I am aware that some procedures I may require may not be a benefit of my particular plan. I also understand that Meetinghouse Dental Care submits my claims to my insurance carrier purely as a courtesy to me. Should insurance payment be denied or should reimbursement be less than the estimated amount, I am responsible for the treatment fee in full.
- If I have dental insurance, I realize that I am responsible for maintaining contact with my insurance carrier through the phone number on my insurance card in order to monitor reimbursement paid throughout the contract year relative to the maximum coverage allowed. I accept sole responsibility for knowing if I have exceeded my max. Should the maximum benefit coverage be exceeded in a given contract year, I am responsible for the balance that remains.
- Meetinghouse Dental Care will strive to protect the privacy of my social security number. If I do not wish to provide my social security number, I agree to pay in full by cash or credit card (no checks) and to accept assignment of benefits if I have insurance.
- I understand that it is my responsibility to advise this office of any changes in the information contained on this form.
- If I am 21 years of age or older and if my parents/guardians are my guarantors, I give permission for Meetinghouse Dental Care to submit dental claims on my behalf to the insurance company to which my parents/guardians subscribe. I give permission for Meetinghouse Dental Care to place a phone call to my parents/guardians regarding claims, account balances, and/or account credits and/or to mail statements or other information to my parents/guardians regarding those claims, account balances, and/or account credits.
- If I am 21 years of age or older and if my parents/guardians are my guarantors, I give permission for Meetinghouse Dental Care to speak to my parents/guardians on my behalf about my existing conditions, recommended treatment, appointments, fees, or other matters that may be relevant to treatment proposed.
- I understand that amalgam fillings contain 48-52% mercury. I understand that Meetinghouse Dental Care will minimize exposure to the team and to me through physical barriers and advanced technology if I need/choose to replace an amalgam filling**:** special bur to section old amalgam into large chunks - Isolite Intra-Oral Protector to pull mercury vapor, particulates, and dust from my oral breathing area - nosehood for clean, uni-directional, continuous-flow nasal air supply - coconut-shell activated charcoal slurry for rinse and swallow and/or chlorella - Ora-Shield dental dam napkin and protective eye wear - LG-2 Ionizers in ceilings of restorative ops - IQAir Dental HG (Mercury) FlexVac - medical-grade oxygen-ozone to sterilize preparation sites - AmalgamBoss Mercury Separator to protect environment – others.
- I understand that any dental work – including replacing filling material - poses risk of trauma to the nerve of the tooth, possibly precipitating tooth loss. Again, a tooth that starts comfortable can be rendered sensitive or even painful during replacement, especially if the tooth has been traumatized in the past or if decay beneath an old dental restoration has drawn too near the nerve.
- Regarding all dental procedures, I understand it is always my option to undergo no dental treatment at all.

Guest Signature_____ Date _____

OR Parent or Responsible Party _____ Relationship to Guest _____ Date _____

Meetinghouse Dental Care is committed to the art of dentistry
through leading-edge technology and personalized, comfortable care.

Like us on Facebook!

Year after year:
named by Consumers' Research Council of America to America's Top Dentists,
by Time Magazine and PennsylvaniaDoctorAwards to PA Best Doctors and Dental Award,
by Global Health and Pharma to Leading Dental Experts in Pennsylvania Award,
by City Beat News to Customer Satisfaction Outstanding Businesses Spectrum Award,
by Opencare to Patients' Choice Award, and by the International Association of Dentists to Top Dentists in Hatboro PA

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