WELCOME

To The Orthodontic Office of Dr. James Meeks

PATIENT INFORMATION

male___ female___ Today's Date ___________________

Name ____ Birthdate ______________ Age _________
First Last

Address ____
Street City Zip

Email _____________________________________ Phone # ______________________________________

Hobbies __________________________________ Referred by ________________________________

Occupation _________________________________ Employer ___________________________________

SPOUSE INFORMATION (If Applicable)

Spouse's Name ____

Phone ________________________________

DENTAL INSURANCE INFORMATION

Name of Insured (Who has the insurance?)____

Birth date_______________________ Social Security Number___________________________

Insurance Company Name ____

Insurance Company Phone ____________________________ ID Number ___________________________

Please provide us with a copy of your dental insurance card. If you have coverage with more than one insurance company, please copy both insurance cards. Thank you!

MEDICAL AND DENTAL HISTORY

Dentist ______________________________ City ____________________________ Phone _______________
Physician ____________________________ City ____________________________ Phone _______________

Have you had any major illness, surgery, medical problems? ___ Yes ___ No
List (if applicable) ____

List any medications you are currently taking____

Are you taking Bisphosphonates? Yes____ No____

For Women: Are you taking birth control pills? ___Yes ___ No
Are you pregnant? ___ Yes ___ No

List any medications you are allergic to ____

List any other allergies (latex gloves, metals, etc.)_____________________________________

Are you currently in good health? ___ Yes ___ No

Do you require antibiotics prior to having routine dental treatment?___ Yes ___ No

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Diabetes
Y N Blood Transfusion
Y N Hepatitis
Y N Rheumatic / Scarlet Fever
Y N Heart Defect / Murmur
Y N Cancer
Y N HIV+/AIDS
Y N Kidney / Liver Problems
Y N Tuberculosis (TB)
Y N Asthma
Y N Bone Disorders
Y N Nervous Disorders
Y N Epilepsy / Convulsions

Have there been any injuries to your face, mouth, teeth, or chin? ___ Yes ___ No
Are you aware of any missing or extra permanent teeth? ___ Yes ___ No
Have you had any jaw joint (TMJ) symptoms or problems? ___ Yes ___ No
Have you had any previous orthodontic treatment? ___ Yes ___ No

Are you aware of any of the following conditions?
Y N Grinding / Clenching Teeth
Y N Abnormal Wear of Teeth
Y N Speech Problems
Y N Bleeding Gums
Y N Unusual (excess) Tarter Buildup
Y N Lip Sucking / Biting

Reason for your visit____

____
Patient’s Signature