MEYER Orthodontics

CONFIDENTAL

Dental/Medical History Form

Patient

Patient's Last Name:_____ First Name:_____ Middle Initial:____
Date Today:_____ Gender: _____ Preferred Pronouns (optional): _____
Age: _____ Birthdate:_____
Home Address: _____ City, State, Zip code: _____
Primary Contact Phone: _____Primary Contact Email:_____
Primary Contact Occupation: _____Primary Contact Employer: _____
Emergency Contact if different from primary: _____ Phone:_____
How did you hear about Meyer Orthodontics? _____
If referred, please list name: _____
Favorite hobbies and activities: _____

_____

_____

Main concerns for your orthodontic treatment: _____

_____

_____

_____

Parent or Guardian Information – if patient is a minor

Parent/Guardian 1 name: _____ Parent/Guardian 2 name: _____
Parent/Guardian 1 email: _____ Parent/Guardian 2 email: _____
Parent/Guardian 1 phone: _____ Parent/Guardian 2 phone: _____
Parent/Guardian 1 birthdate: _____ Parent/Guardian 2 birthdate: _____
Parent/Guardian 1 occupation & employer: _____
Parent/Guardian 2 occupation & employer: _____
Who is the primary contact on the account: _____

Dental Insurance Information

Primary Insurance:
Primary Insured's Name:_____ Birthdate: _____
Primary Insured's Address: _____ City, State, Zip: _____

--Continued on Page 2—

Social Security Number (used to verify benefits): _____
Insurance Company: _____ Insurance Co Phone: _____
Insurance Co. Address: _____
Policy #: _____ Group #: _____

OFFICE USE ONLY: Max: _____ Used: _____ Balance: _____
Deductible: _____Date Verified: _____Waiting Period: _____

Secondary Insurance:
Secondary Insured's Name:_____ Birthdate: _____
Secondary Insured's Address: _____City, State, Zip: _____
Social Security Number (used to verify benefits): _____
Insurance Company: _____Insurance Co Phone: _____
Insurance Co. Address: _____
Policy #: _____ Group #: _____

OFFICE USE ONLY: Max: _____ Used: _____ Balance: _____
Deductible: _____Date Verified: _____Waiting Period: _____

Dental History

Patient's Dentist: _____ Date Last Seen: _____
Any other family member being/was treated by Meyer Orthodontics? ___Y ___N Name:_____
Has patient been evaluated for ortho treatment? ___Y ___N If yes, Doctor's Name:_____
Has patient been treated for or been told they have periodontal (gum) problems? ___Y ___N
If so, explain:_____
Does patient have:

Thumb or finger habit	___Y ___N	Grinding of teeth	___Y ___N
Injuries to face, jaw, teeth	___Y ___N	Clenching of teeth	___Y ___N
Bleeding gums.	___Y ___N	Nail biting	___Y ___N
Mouth breathing	___Y ___N		

--Continued on Page 3—

Medical History

Patient's Physician: _____

List of all medications the patient is currently taking: _____

_____

Does the patient have allergies to medications? ___Y ___N Please list:_____

Does the patient have any other allergies? ___Y ___N Please list:_____

Does the patient have any birth defects? ___Y ___N Please list:_____

Please check if the patient has had any of the following:

AIDS/HIV	___	Endocrine Problems	____	Kidney Problems	____
Anemia	___	Epilepsy	____	Liver Problems	____
Artificial Heart Valves	___	Fever Blisters	____	Mitral Valve Prolapse	____
Asthma	___	Heart Attack/Stroke	____	Nervous Problems	____
Blood Disease	___	Heart Murmur	____	Prolonged Bleeding	____
Bone Disorders	___	Heart Problems	____	Rheumatic Fever	____
Cancer	___	Hemophilia/Bleeding	____	Severe/Frequent Headaches	____
Diabetes	___	Hepatitis	____	Sinus Problems	____
Drug/Alcohol Abuse	___	Kidney Disease	____	Tuberculosis	____

Form Authorization

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian (if patient is minor): _____ Date: _____