Greenville FAMILY DENTAL

1717 W Washington St
Greenville MI 48838
P:616.754.8631 F:616.754.0519
www.GreenvilleFamilyDental.com

Tara L. Meachum, DDS, FAGD

Patient Information

Name:_____ Preferred/Nickname:_____ Gender:_____

Birthdate:_____ SS#:_____ Email:_____

Cell phone:_____ Home phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Family status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Child

Whom may we thank for referring you? _____

Dental History

Your prior dentist's name:_____ Last dental visit:_____

	Yes	No
History of periodontal disease?.....	☐	☐
Do your gums bleed when brushing or flossing?.....	☐	☐
Are any of your teeth loose?.....	☐	☐
Are any of your teeth painful?.....	☐	☐
Are your teeth sensitive to sweet/sour foods?.....	☐	☐
Are your teeth sensitive to cold/hot foods?.....	☐	☐
Do you have lumps or sore in/around your mouth?.....	☐	☐
Do you have a dry mouth?.....	☐	☐
Have you had orthodontic treatment?...	☐	☐
Do you grind your teeth?.....	☐	☐
Do you have difficulty opening/closing your mouth?.....	☐	☐

	Yes	No
Do you have pain or clicking in your jaw joints?.....	☐	☐
Do you have frequent headaches?.....	☐	☐
Have you had any head, neck, or jaw injuries?.....	☐	☐
Have you had difficult extractions or prolonged bleeding from extractions?.....	☐	☐
Do you currently wear dentures or partials?.....	☐	☐

If so, what is the approximate date of placement?_____

If any of the previous questions are marked yes, please explain:_____

_____

_____

Medical History

Please indicate if you have ever experience any of the following:

☐ADHD
☐Anemia
☐Anxiety
☐Arthritis
☐Artificial joints
☐Artificial valves
☐Blood disease
☐Cancer
☐Chest pain
☐Depression
☐Diabetes
☐Dizziness
☐Emphysema
☐Endocarditis
☐Epilepsy
☐Excessive bleeding
☐Fainting
☐Glaucoma
☐Head injury
☐Heart attack
☐Heart disease
☐Heart murmur
☐Hepatitis
☐High blood pressure
☐HIV/AIDS
☐High cholesterol
☐Kidney disease
☐Liver disease
☐Low blood pressure.
☐Mental disorders
☐MRSA
☐Pacemaker
☐Radiation treatment
☐Respiratory problems
☐Rheumatoid arthritis
☐Sinus problems
☐Sleep apnea
☐Stomach problems
☐Stomach ulcers
☐Stroke
☐Thyroid problem
☐Tuberculosis

Medical History (continued)

	Yes	No
Are you currently under the care of a physician for a specific condition?.....	☐	☐
Have you been hospitalized in the last 2 years?.....	☐	☐
Have you had gastric bypass surgery?.....	☐	☐
If so, when?_____		
Do you use tobacco?.....	☐	☐
Smoking, chewing, or vaping? _____		
Do you snore or have you been told you snore?.....	☐	☐
Have you had a sleep study or been told to get a sleep study?.....	☐	☐
Do you wear a C-Pap?.....	☐	☐
Have you ever taken any of the following? Fosamax, Boniva, Actonel, Didronel, Skelid or IV Reclast, or any other medications containing bisphosphonates? (These are bone building medications).....	☐	☐

	Yes	No
Do you currently use, or have you ever had a problem with controlled substances?.....	☐	☐
Do you use inhalers regularly?.....	☐	☐
Has your family physician ever recommended that you regularly take antibiotics before a dental procedure (sometimes called pre-med)?.....	☐	☐
Women only:		
Are you pregnant?.....	☐	☐
Are you nursing?.....	☐	☐
Are you taking oral contraceptives?.....	☐	☐

Current medications:_____

_____

_____

Are you allergic to any of the following? ☐Latex ☐Codiene ☐Local anesthetics ☐Penicillin ☐Metals

Other:_____

If any of the above are marked yes, please explain:_____

_____

Who is your primary care physician? _____ Date of last exam:_____

Authorization and Release

I hereby certify that I have read and understand the previous information. I acknowledge that providing inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnostic and treatment or examination records for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsibly for payment of all services on my behalf or on the behalf of my dependents (if any).

Signature of patient (or parent/guardian if minor):_____ Date:_____

Doctor's comments:_____

_____

_____

_____Doctor's signature:_____ Date:_____