MeadowsFamilyDentistry
pediatric • orthodontic • adult care

Smiles for Life

Adult Registration

Tell us about yourself: **Date:** _____

Patient's Full Name: _____ Sex: M F Patient D.O.B: _____/_____/_____

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Driver's License #: _____ Social Security: _____ - _____ - _____

Height: _____ Weight: _____ Previous Dentist: _____ How did you hear about us? _____

Employer: _____ Occupation: _____ How Long: _____

Patient is: Single Married Separated Divorced Widowed

Spouse's Name: _____ Spouse's Employer: _____ Occupation: _____

In case of Emergency, Please notify: _____ Relation: _____ Phone: _____

Preferred Pharmacy: _____ Phone: (__) _____

Pharmacy Location: _____

Insurance Information

Do you Have Dental Insurance? Yes No Insurance Co. Name: _____ Phone: _____

Insurance Company Address: _____ State: _____ Zip: _____

Ins. Subscriber Name: _____ Subscriber SSN: _____ - _____ - _____

Subscriber DOB: _____/_____/_____ Patient's Relationship to Insured: Self Spouse Child Partner Other

Member ID# (may be SSN): _____ Policy/Group #: _____

Do you Have Secondary Insurance? Yes No Insurance Co. Name: _____ Phone: _____

Insurance Company Address: _____ State: _____ Zip: _____

Ins. Subscriber Name: _____ Subscriber SSN: _____ - _____ - _____

Subscriber DOB: _____/_____/_____ Patient's Relationship to Insured: Self Spouse Child Partner Other

Member ID# (may be SSN): _____ Policy/Group #: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you in advance for answering the following questions. All information will be kept confidential.

Are you currently under the care of a physician? Yes No If Yes: _____

Have you ever been hospitalized or had a major operation? Yes No If Yes: _____

Have you ever had a serious head or neck injury? Yes No If Yes: _____

Have you ever had a serious illness not listed above? Yes No If Yes: _____

Do you take or have you taken Phen-fen or Redux? Yes No If Yes: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If Yes: _____

Have you ever been or are you currently being treated with anticoagulants? Yes No If Yes: _____

Have you ever been or are currently being treated for MRSA? Yes No If Yes: _____

Are you on a special diet? Yes No If Yes: _____

Do you use Tobacco (Smoke / Dip)? Vape? How often? Yes No If Yes: _____

Women: Are you… Pregnant Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Do you have allergies to any other medications? Yes No If Yes: _____

Do you use any of the following prescribed medications/substances? Oxycodone Vicodin Tylenol with Codeine Marijuana Valium Xanax Adderall

Please list any Medications you are taking (Include purpose if not listed below):

Do you have or ever had any of the following?

___ AIDS/HIV Positive
___ Alzheimer 's disease
___ Anaphylaxis
___ Anemia
___ Angina
___ Anxiety
___ Arthritis/Gout
___ Artificial Heart Valve
___ Artificial Joint
___ Asthma
___ Autism
___ Blood Disease
___ Blood Transfusion
___ Breathing Problems
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Chest Pains
___ Cold Sore/Fever Blister
___ Congenital Heart Disorder
___ Convulsions
___ Cortisone Medicine
___ Depression
___ Diabetes
___Drug Addiction
___Emphysema
___Epilepsy or Seizures
___ Excessive Bleeding
___ Excessive Thirst
___ Fainting/Dizziness
___ Frequent Cough
___ Frequent Diarrhea
___ Frequent Headaches
___ Herpes/Genital Herpes
___ Glaucoma
___ Hay Fever
___ Heart Attack/Failure
___ Heart Murmur
___ Heart Pacemaker
___ Heart Trouble/Disease
___ Hemophilia
___ Hepatitis A B or C
___ High Blood Pressure
___ High Cholesterol
___ Hives or Rash
___ Hypoglycemia
___ Irregular Heartbeat
___ Kidney Problems
___ Leukemia
__ Liver Disease
___ Low blood Pressure
___ Lung Disease
___ Mitral Valve Prolapse
___ Osteoporosis
___Pain in Jaw Joints
___ Parathyroid Disease
___ Psychiatric Care
___ Radiation Treatment
___ Recent Weight Loss
___ Renal Dialysis
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Shingles
___ Sickle Cell Disease
___ Sinus Trouble
___ Spina Bifida
___ Stomach Disease
___ Stroke
___ Swelling of Limbs
___ Thyroid Disease
___ Tonsillitis
___ Tuberculosis
___ Tumors or Growths
___ Ulcers
___ Venereal Disease
___ Yellow Jaundice
___ *Any condition not listed:
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's (Patient's Representative) Signature: _____

We take great pride in providing the BEST care available!!

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Medical/ Recreational Marijuana Disclosure

It is important to disclose any marijuana use to your dentist before undergoing dental treatment using local anesthesia. The use of marijuana may increase the risk of cardiovascular complications during the procedure. Be honest about your use; don't downplay or underestimate how much you use. Remember: marijuana use can impact the effectiveness of your anesthetic, so accurate disclosure is your best chance at a comfortable procedure. As uncomfortable as it may be to disclose substance use to your healthcare providers, it is essential if you want to receive top-notch care.

Risk of Dental Local Anesthetic with Marijuana Use:

Doctors and researchers have found that patients who use marijuana usually require more anesthetic to achieve adequate numbing and comfort. Epinephrine in local anesthetic may cause the heart rate to increase, if more local anesthetic is required, there might be a greater potential of causing a cardiac event.

Effects on Blood Pressure with Marijuana Use:

Experts believe that marijuana may increase blood pressure and heart rate. This is likely linked to the dose of marijuana used, with higher amounts causing a more severe impact. For this reason, people with high blood pressure may want to avoid heavy marijuana use. Normal blood pressure is 120/80 or lower. High blood pressure is 140/90 or higher.

Even though it can cause high blood pressure, marijuana is also linked to a sudden drop in blood pressure when a person shifts from sitting to standing (orthostatic hypotension).

If you answer yes on our Medical/Medical Marijuana Liability Form as to consuming marijuana within 24 hours of appointment, we will check your blood pressure before administering local anesthesia. If your blood pressure is elevated too high, the Dr. will determine if we need to reschedule you.

I certify that I have read and fully understand this document and all my questions were answered.

Name_____ Date_____

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FINANCIAL RESPONSIBILITY
& ASSIGNMENT OF INSURANCE BENEFITS FOR:

I understand that services rendered to me by Meadows Family Dentistry are my financial responsibility and that Meadows Family Dentistry will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Meadows Family Dentistry and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional services charges over and above the estimated insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim.

I authorize Meadows Family Dentistry to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize Meadows Family Dentistry to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payments to me, I will forward the payment to Meadows Family Dentistry within 48 hours. I agree that if I fail to send the payment to Meadows Family Dentistry and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Meadows Family Dentistry. Any violations of this agreement will, at Meadows Family Dentistry election, terminate Patient charge privileges with Meadows Family Dentistry and bring any balance owed by Patient to Meadows Family Dentistry immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Meadows Family Dentistry to facilitate payment utilizing the credit card number on file to resolve the balance.

**IF INSURANCE BENEFITS PREVIOUSLY QUOTED DEFAULT FOR ANY REASON, THE UNPAID BALANCE WILL BECOME THE RESPONSIBILITY OF THE PATIENT/PATIENT'S GUARDIAN.*

_____ _____ _____

Signature of Policyholder/Representative *Print Name* *Relation to Patient*

_____

Date

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HIPAA Disclosure and Release of Information

I, _____, hereby authorize Meadows Family Dentistry, LLC (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have received and reviewed a copy of the NOPP, been given an opportunity to ask questions about it, understand it and do here by agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

_____ _____ _____

Patient Name Signature of patient or parent/guardian Date

Consent for Communication and/or Disclosure

I request the following alternative or limitations relating to communication directed to me by my healthcare provider or employee of Meadows Family Dentistry, LLC. I understand that this HIPAA consent applies to ALL providers of Meadows Family Dentistry. It is my responsibility to notify Meadows Family Dentistry of any changes.

Do we have permission to:

Send appointment reminders via (please check the following): TEXT ☐ EMAIL ☐ BOTH ☐

Leave the following information on your home/cell voicemail?

Appointment Information ___Yes___No

Billing Information ___Yes ___No

Medical Information ___Yes ___No

I give my permission to share the following information with the person(s) listed below:

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical: ___Yes ___No

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical :___Yes ___No

_____ _____ _____

Patient Name Signature of patient or parent/guardian Date