Welcome

Michael M. Cammann DMD
John W. Cammann DMD
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R. Erik Cantwell DDS

PATIENT INFORMATION

Name: (Last)__________________________(First)_______________________(Middle)_______

Date of Birth:_______________Age:_____M F Social Sec #___________________________

Home Address: ______________________________City:___________State:_____Zip_______

Mailing Address: _____________________________City:___________State:_____Zip_______

Home Phone:_________________Work #___________________ Cell Phone:_________________

Name of Responsible Party:_____________________________Social Sec #________________

Home Address:____
(If different from above) city State zip code

Date of Birth:_____________Relationship to patient:___________Social Sec #______________

Employer:___________________________________ Business Phone:______________________

Drivers License #:__________________________

Emergency Contact:_______________________Relationship:___________Ph#______________

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

DENTAL HISTORY

Last Dental Visit?_______________How often do you brush?__________Floss?______________

Are your teeth sensitive to: Sweets Biting Hot Cold Other

Do your gums bleed? Yes No Do you clench or grind your teeth? Yes No

What qualities do you look for in a dental office?_______________________________________

MEDICAL HISTORY

Have you had or do you have any of the following:

Yes	No	Allergies	Yes	No	Hepatitis Type_____
Yes	No	Anemia	Yes	No	Headaches Severe/Frequent
Yes	No	Artificial Bones Joints	Yes	No	Heart Condition Congenital Murmur Attack/Stroke Heart Surgery Pacemaker Mitral Valve Prolapse
Yes	No	Asthma			
Yes	No	Artificial Valves			
Yes	No	Blood Pressure Problems High Low	Yes	No	Hemophilia/bleeding
Yes	No	Blood Transfusion	Yes	No	HIV+/AIDS
Yes	No	Breathing Problems	Yes	No	Kidney Problems
Yes	No	Cancer Chemo Radiation	Yes	No	Osteoporosis
Yes	No	Depression/Psychiatric	Yes	No	Rheumatic Fever
Yes	No	Diabetes – Type____	Yes	No	Shingles
Yes	No	Drug/Alcohol Abuse	Yes	No	Smoke/Chew Tobacco
Yes	No	Emphysema	Yes	No	Sinus Problems
Yes	No	Epilepsy/Seizures	Yes	No	Tuberculosis
Yes	No	Fainting Spells	Yes	No	Ulcers/Colitis
Yes	No	Fever Blisters/Canker sores	Yes	No	Venereal Disease
Yes	No	Glaucoma	Yes	No	Pre-Medication for dental treatment (Antibiotic)

Please list any additional conditions not listed above:____

List any medications you are currently taking:____

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____

Allergies: Please Check any that apply:

Penicillin Erythromycin Tetracycline Aspirin Codeine None

Dental Anesthetics Latex other______________________________

Woman: Are you? Pregnant Nursing Using birth control

Physician's Name:________________________Are you presently under phys care Yes No

DENTAL INSURANCE INFORMATION

Primary:
Insurance Company: ____

Insurance Company Address:____

City:____________________State:__________Zip:___________

Subscriber's Name: __________________________________Date of Birth:______________

Subscriber's SSN or ID #____________________________Policy/grp #__________________

Subscriber's Employer: ______________________________Bus Ph #__________________

Secondary:
Insurance Company: ____

Insurance Company Address:_ ____

City:____________________State:__________Zip:___________

Subscriber's Name: __________________________________Date of Birth:______________

Subscriber's SSN or ID #____________________________Policy #_____________________

Subscriber's Employer: ______________________________Bus Ph #__________________

FINANCIAL-APPOINTMENT-MEDICAL & INSURANCE RELEASE

The information I have given today is correct to the best of my knowledge.

I have been advised of the HIPAA Privacy protection provided by this office.

I will hereby advise the office of any and all medical changes at each appointment.

I hereby authorize direct payment from my insurance company to Meridian-Middleton Dental, and further authorize release of any and all information requested by the insurance company for processing of my dental claims.

I am financially responsible for all charges, regardless of my insurance coverage. I also realize that it is my responsibility to be familiar with my insurance policy.

Payment is due AT TIME OF SERVICE; If I have insurance, any and all co-payments and/or deductibles are due at the time of service. In accordance with the Federal Truth-in-Lending Act, I realize that any balance over 60 days may be subject to a billing charge of $5 or 21% APR.

If I refuse to provide my SSN, I agree to pay IN FULL with credit card or cash, regardless of my insurance status.

A $75 fee may be charged for missed appointments without a 24-hour notice.

Signature Responsible Party____________________________________Date___________