MONTICELLO
FAMILY DENTISTRY

Lindsey Meyer, D.D.S.
(319) 465-3533
630 S. Main St. • P.O. Box 416
Monticello, Iowa 52310

PATIENT INFORMATION (CONFIDENTIAL)

Patient # _____

Date _____

Name _____ Birth Date _____ Social Security # _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Email Address _____

Sex: Male _____ Female _____ _____ Minor _____ Single _____ Married _____ Divorced _____ Widowed

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Who is financially responsible for this bill? _____

Whom may we thank for referring you? _____

Person to contact in case of an Emergency _____ Phone _____

Family Physician _____ Phone _____

INSURANCE INFORMATION:

Name of Insured _____ Birth Date _____ Social Security # _____

Name and Address of Employer _____ Phone _____

Insurance Company Name and Address _____ Group # _____

GENERAL INFORMATION:

What is the reason for today's visit? _____

Do you have any questions or concerns we can help you with today? _____

Do you love your smile? _____ Is there anything you would like to change? _____

Why did you leave your last dentist? _____

MEDICAL HISTORY AND INFORMATION:

Do you have or ever had?

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart problem
- ☐ Hepatitis __A __B __C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other _____
- ☐ Other _____

Are you currently under the care of a physician? ☐ Yes ☐ No Please explain _____

Are you currently taking any medication? ☐ Yes ☐ No Please explain _____

Do you use tobacco? ☐ Yes ☐ No

Are you Allergic to? ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Other

Female Patients, are you Pregnant? ☐ Yes ☐ No If yes, due date _____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.
I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered, regardless of insurance status. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes to the above information.

Signature _____ Date _____

Parent or Guardian (if a minor) _____ Date _____

E-mail _____