Dr. Steven Meier, DDS, MSD
Specialist in Orthodontics

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1. **Adult Patient Information**

Last Name_____, First Name_____, M. I.____
I prefer to be called: _____
Gender: Male____ Female____
Age: ____ Birthdate: _____/_____/_____ Driver's License Number _____
Home Telephone Number: (_____)_____-_____Cell Phone Number: _____
May we text you appointment reminders? Yes ☐ No ☐
Home Address: Street: _____Apt. No.: _____
City: _____ Zip Code: _____
E-mail address _____
Employer's Name and Address: _____
Work Telephone Number: (_____)_____-_____ Extension: _____
In an emergency whom should we contact? _____ (_____)_____-_____
Emergency contact's relationship to patient?_____
General Dentist: _____ Date of last dental visit: _____
Whom may we thank for referring you? _____
What are the main concerns or problems for orthodontics to correct? _____
_____

2. **Person Responsible for Account**

Name: _____ SS Number: _____-_____-_____
Relationship: _____ Driver's License Number: _____
Address if different from yours _____
Telephone number if different from yours: Home (_____)_____ Work (_____)_____

3. **Dental and Medical History**

Physician: _____
Date of last medical visit: _____
Is your current physical health ____Good, ____Fair, ____Poor?
Medications currently taking: _____
Allergies to medications, metals, latex, plastics or other (specify): _____
Have there been any injuries to the face, mouth and chin? ____Yes, ____No
Have you ever been informed of any missing or extra permanent teeth? ____Yes, ____No
Do you brush your teeth daily? ____Yes, ____No
Do you floss your teeth daily? ____Yes, ____No

4. **Primary Dental and Orthodontic Insurance**

Company: _____
Address: _____
_____
Telephone Number: (_____)_____
Policy Group Number: _____
Policy Owner's Name: _____
Policy Owner's Date of Birth: _____
Policy Owner's SS Number: _____-____-_____
Policy Owner's Employer: _____

Secondary Dental and Orthodontic Insurance

Company: _____
Address: _____
_____
Telephone Number: (_____)_____
Policy Group Number: _____
Policy Owner's Name: _____
Policy Owner's Date of Birth: _____
Policy Owner's SS Number: _____-____-_____
Policy Owner's Employer: _____

Please continue completing of this form on the reverse side

Have you ever had any of the following medical problems? If yes please explain below:

____Yes ____No Abnormal bleeding
____Yes ____No Anemia
____Yes ____No Artificial Bones/ Joints/ Heart Valves
____Yes ____No Asthma
____Yes ____No Arthritis
____Yes ____No Blood Transfusion
____Yes ____No Cancer
____Yes ____No Chemotherapy/ Radiation (X-Ray) Treatment
____Yes ____No Congenital Heart Defect
____Yes ____No Convulsions/Epilepsy/ Seizures/ Fainting
____Yes ____No Diabetes
____Yes ____No Difficulty Breathing
____Yes ____No Drug/ Alcohol Abuse
____Yes ____No Emphysema
____Yes ____No Handicaps/Disabilities
____Yes ____No Headaches
____Yes ____No Heart Murmur/Attack/Stroke/Surgery/Pacemaker/Valve Defects
____Yes ____No Hemophilia
____Yes ____No Hepatitis
____Yes ____No High/Low Blood Pressure
____Yes ____No HIV+/AIDS
____Yes ____No Kidney/Liver Problems
____Yes ____No Mental Health Care
____Yes ____No Rheumatic/Scarlet Fever
____Yes ____No Sinus Problems
____Yes ____No TMD/TMJ jaw joint problems
____Yes ____No Tuberculosis (TB)
____Yes ____No Ulcers/Colitis
____Yes ____No Venereal Disease
____Yes ____No Viral Infections/ Fever Blisters/ Herpes/Shingles

Please describe any hospital stays, operations or yes answers above.

_____

Have you had in the past, or presently have any of the following habits?

____Yes ____No Clenching/Grinding Teeth
____Yes ____No Lip Sucking/Biting
____Yes ____No Mouth Breathing
____Yes ____No Nail Biting
____Yes ____No Thumb/Finger ____Days ____Nights. If stopped, what age? ____
____Yes ____No Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status, address, and telephone number**. (<u>There will be a $30 fee for No Show and less than 24 hr. cancellation notice for appointments.)</u>** I also give permission to release information to my insurance company(ies) to expedite payment for services, and understand that I am responsible for all fees incurred. I understand that Person(s) offered the Butler Orthodontics Office Fee Plan are subject to a credit check and approval of credit. The Care Credit Finance Option is offered only on Full Care fee payment. (If an interpreter is needed at your appointment, it is your responsibility to have one with you at the time of your appointment.)

_____ ____/____/____

Signature of patient Date

Review of dental/medical information Dr.'s initials _____ Date____/____/____