Reliant
FAMILY DENTAL
Chris Meunier DDS

PATIENT REGISTRATION

www.ReliantFamilyDental.com
4827 Davis Lant Drive, Suite G
Evansville, Indiana 47715
(812) 402-7676

Patient Name _____ Preferred Name_____
First Middle Last

Marital Status: □Single □Married □Divorced □Widowed Spouse's Name:_____ Spouse's Phone # ( )_____

Birth Date _____ Age_____ SS#_____

Employer_____Occupation_____ Referred By_____

Home Address_____ Zip_____

Home# ( )_____ Cell# ( )_____Work # ( )_____

E- Mail Address:_____ Preference of appointment confirmation: □Text □Email □Call

Person Responsible for Account (if different)_____ Relationship_____

SS#_____ Home# ( )_____ Cell# ( )_____

Employer_____Occupation_____Work # ( )_____

Do you have Dental Insurance? Yes_____ No_____ With Whom?_____

Nearest Relative Not Living With You_____Relationship_____Phone# ( )_____

Dental History/Information:

Previous Dentist_____Physician_____

Reason for today's visit: _____How often do you brush?_____ How often do you Floss?_____

Is there anything you would change about your smile? If so, what?_____

Medical History/Information: *Please check yes or no:*

Are you currently under the care of a physician?	☐ Yes	☐ No	Explain:_____
Are you Pregnant?	☐ Yes	☐ No	How many weeks?_____
Have you ever had high blood pressure?	☐ Yes	☐ No	Explain:_____
Has a physician ever said you had heart problems?	☐ Yes	☐ No	Explain:_____
Do you have any artificial joints (such as knee or hip)?	☐ Yes	☐ No	Explain:_____
Has a physician or dentist ever said you had a tumor or cancer?	☐Yes	☐ No	Explain:_____
Are you allergic to Penicillin, Novocain or any other medicine?	☐Yes	☐ No	Explain:_____
Has a Doctor EVER recommended an antibiotic prior to dental treatment?	☐ Yes	☐ No	Explain:_____
Are you allergic to anything other than medicine? (e.g: latex or metals)?	☐Yes	☐ No	Explain:_____
Have you ever had an unusual reaction to a dental anesthetic?	☐Yes	☐ No	Explain:_____
Have you ever had abnormal bleeding following a dental extraction?	☐ Yes	☐ No	Explain:_____

Do you use any tobacco products? ☐ Yes ☐ No Type?_____How Often?_____

Are you now, or **have you ever** taken medicine for Osteoporosis (Boniva, Fosamax, Actonel, Reclast etc)? ☐ Yes ☐ No

Please list **ALL medications you are currently taking: _____

_____

Please check all that apply to you:

☐ Clicking or popping TMJ/joint	☐ Bad Breath	☐Sensitivity to hot/cold/sweets	☐Sores or growths in your mouth
☐Frequent head aches	☐Bleeding gums	☐Fears about dental treatment	☐Swelling in mouth/neck
☐Grinding/clenching habit	☐Periodontal (Gum) treatment	☐Previous injury to mouth or jaw	☐ Previous surgery in mouth

Do you now or have you EVER had any of the following:

☐ Rheumatic fever or Rheumatic heart disease?	☐ Arthritis	☐ Liver trouble or jaundice	☐ Hepatitis	☐Eczema or hives	☐Stomach Ulcer
☐ Mitral Valve Prolapse or Heart Murmur	☐ Asthma or hay fever	☐Thyroid trouble or goiter	☐Psychiatric treatment	☐ HIV / AIDS	☐ Anemia, leukemia or low platelets
☐ Epilepsy or convulsions	☐ Tuberculosis	☐Glaucoma	☐ Stroke or heart attack	☐Kidney Trouble	☐Fainting or dizziness
	☐ Diabetes				

Signature _____ **Date**_____

I Understand That Payment Is Due At Time Of Service. I will pay today by: CASH ❑ CHECK ❑ CREDIT CARD ❑

There is a $20 service fee for each returned check

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC, and the ADA