Meridian Dental

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(907)376-9200

Please Review and Update any Necessary Changes

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ____________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **Prev. Visit:** ____________ **Email Address:** ____________

Phone: ____________ ____________ ____________ ________ **Best time to call:** ____________
Home Mobile Work Ext

Address: ____________ ____________
Address 1 Address 2

____________ ________ _____-____
City State Zip Code

- ☐ *Pre-Med - Amox
- ☐ Aids/HIV Positive
- ☐ Allergy - Anesthetic
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bisphsphonates
- ☐ Blood Disease
- ☐ Blood Pressure-High
- ☐ Blood Pressure-Low
- ☐ Blood Thinner
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Herpes
- ☐ Diabetes Type I/II
- ☐ Dizziness/Fainting
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Head/Neck/Jaw Injury
- ☐ Heart Disease/Attack
- ☐ Heart Murmur
- ☐ Hemophilia/ Bleeding
- ☐ Hepatitis A, B, C
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental/Nervous Dis
- ☐ Osteoporosis
- ☐ Other Allergy/Med
- ☐ Other
- ☐ Pacemaker/Stents
- ☐ Pain in Jaw/Joints
- ☐ Penicillin/Amox
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ STD/HPV
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Taking Medications
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers

Do you use any tobacco products? ◯ Yes ◯ No

Are you currently taking blood thinners? ◯ Yes ◯ No

Have you ever take oral or iv bone density medication for osteoporosis/osteopenia?
(Bisphosphonates, Fosamax, Zometa, Prolia) ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? If yes, please explain. ◯ Yes ◯ No

If you are on birth control please be advised that if you take antibiotics this may compromise the effectiveness of your birth control.

☐ Ever been hospitalized (illness or injury) ☐ Presently being treated for any other illnesses ☐ Subject to frequent headaches
☐ FEMALE: Taking birth control pills ☐ FEMALE: Pregnant

List all medications (prescription and non-prescription) including regular doses of aspirin:

___

___

Consent for Use and Disclosure of Health Information

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide wheather to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and compleletly before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Dr.Gurr
Telephone: 907-376-9200
E-mail: meridiandentalak@gmail.com
Address: 3465 E. Meridian Park LP Ste C. Wasilla, AK 99654

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

☐ * **By signing this Consent I agree that I have had full oppurtunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activites, and healthcare operations.**

☐ *I understand that Meridian Dental, LLC is not responsible for any fees regarding travel to and from the office.

Response Date: ____/____/________