CITYTOOTH
Comprehensive Dentistry
www.citytooth.com

Tripti A. Meysman, DDS

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date
Home Phone
Cell Phone
Last Name
First Name
Middle Initial
Address
City
State
Zip Code
Email
SS/HIC/Patient ID#

Whom may we thank for referring you?

Sex ☐ M ☐ F
Age
Birthdate
Married ☐ Widowed ☐ Single ☐ Minor ☐
Separated ☐ Divorced ☐ Partnered for years

Patient Employer/School
Occupation
Employer/School Address
Employer/School Phone Number

In case of emergency who should be notified?
Phone Number

Primary Insurance

Person Responsible for Account:
Last Name
First Name
Middle Initial
Relation to Patient
Home Phone
Cell Phone
Address (if different from patient's)
City
State
Zip Code
Insurance Company
Contract #
Group #
Subscriber #

Age
Birthdate
Social Security #
Person Responsible Employed by
Occupation
Business Address
City
State
Zip Code
Business Phone

Names of other dependents covered under this plan

Additional Insurance

Is patient covered by additional insurance? Yes ☐ No ☐
Subscriber Name
Relation to Patient
Home Phone
Cell Phone
Address (if different from patient's)
City
State
Zip Code

Birthdate
Social Security #
Insurance Company
Contract #
Group #
Subscriber #

Names of other dependents covered under this plan

Please complete both pages.

Dental History

Reason for Today's Visit

Former Dentist

Address

State

Zip

How often do you floss?

How often do you brush?

Date of last dental care

Date of last dental x-rays

Check box if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding Gums
- ☐ Clicking jaw
- ☐ Food collection between teeth
- ☐ Sores/growths in your mouth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sensitivity to cold

Medical History

Physician's Name

Date of Last Visit

(Women) Are you pregnant? Yes ☐ No ☐

Nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

Have you ever had a blood transfusion? Yes ☐ No ☐

If yes, give approximate dates

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ☐ No ☐

Have you had any serious illnesses or operations? Yes ☐ No ☐

If yes, describe

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications. List any medications you are currently taking:

Allergies

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Dr. Tripti Meysman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date

Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.