Patient Information

Name:_____, _____, ____; I go by: _____
Last First MI

Family Status: Married Single Child Other

Birthdate: ___/___/_____ SSN:_____-___-____ DL#: _____

Email:_____ Employment: _____

Phone: (_____) ____-_____ (_____) ____-_____ (_____) ____-_____ _____
Home Mobile Work EXT

Address:_____ City:_____ State: ____ Zip:_____

Preferred Appointment Time: Any time Mornings Afternoon
Monday Tuesday Wednesday Thursday

Whom may we thank for referring you to our practice? _____

What would like Dr. Meharry to do for you first? _____

What do you want to change about your smile? _____

Spouse or Responsible Party

Name:_____, _____, ____; I go by: _____
Last First MI

Family Status: Married Single Child Other

Birthdate: ___/___/_____ SSN:_____-___-____ DL#: _____

Email:_____ Employment: _____

Phone: (_____) ____-_____ (_____) ____-_____ (_____) ____-_____ _____
Home Mobile Work EXT

Address:_____ City:_____ State: ____ Zip:_____

Patient's Medical History

Please circle any of the following conditions that you have or have had in the past:

Anemia	Arthritis	Artificial Heart Valves
Artificial Joints	Asthma	Blood Disease
Cancer	Chemical Dependency	Chemotherapy
Cortisone Treatments	Cough, Persistent	Diabetes
Epilepsy	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	Rheumatism
Scarlet Fever	Shortness of Breath	Skin Rash
Stroke	Swelling of Feet/Ankles	Thyroid Problems
Tobacco Habit	Tuberculosis	Ulcer
Allergies – Codeine	Allergies – Dye	Allergies – Erythromycin
Allergies – Latex	Allergies – Penicillin	Allergies – Sulfa
Allergies – Other (please state) _____		None of these