# BROADWAY FAMILY DENTAL

PETER MEANEY D.M.D.
291 BROADWAY
Lynn MA 01904
(781)592-5919

## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. ____
FOR OFFICE USE ONLY

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

Title: ____ Mr/Ms/Mrs/etc  Gender: ○ Male ○ Female  Family Status: ○ Married ○ Single ○ Child ○ Other

Birth Date: ____ Prev. Visit: ____ Email Address: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile  Best time to call: ____

Address: ____ ____
____ City ____ State ____ Zip Code

RESPONSIBLE PARTY NAME

____

RESPONSIBLE PARTY ADDRESS AND PHONE #

____

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____ Phone: ____

Address: ____ ____
____ City ____ State ____ Zip Code

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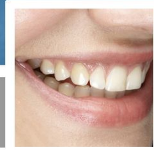

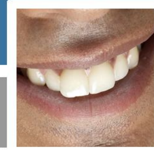

# Primary Insurance Information

## Primary Dental Insurance:

Name of Insured: ______ ______ ______
Last First MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ ______ ______
City State Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ ______ ______
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: ______

Insurance Address: ______ ______
______ ______ ______
City State Zip Code

# MEDICAL HISTORY

Are you under medical treatment now?

◯ Yes ◯ No

If yes, please explain:

Please list any current medications, including non prescription medicine that your take:

Have you ever taken Fosamax, Boniva, Actonel or any cancer medication containing bisphosphonates?

◯ Yes ◯ No

Are you allergic to or have you had a reaction to the following?

- ☐ local anesthetic (e.g. novocain)
- ☐ sulfa drugs
- ☐ sedatives
- ☐ asprin
- ☐ latex rubber
- ☐ Penicillin or any other antibiotic
- ☐ barbiturates
- ☐ iodine
- ☐ any metals (e.g. nickel, mercury, ect)

Do you have or have you ever had any of the following? Please check all that apply.

- ☐ Allergies
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Dizziness
- ☐ Fainting
- ☐ Anemia
- ☐ Asthma
- ☐ Codeine Allergy
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Growths

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- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Pregnancy
- [ ] PreMed
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please check below if any apply to you:

- [ ] use tobacco
- [ ] use controlled substances
- [ ] wear contact lenses

Women Only:

- [ ] Are you pregnant or think you may be pregnant?
- [ ] Are you nursing?
- [ ] Are you taking oral contraceptives?

Person to contact in case of emergency

Physician Name and Phone Number.

Please list anything you feel in relevant to your health not covered on this form

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# Financial Policy

Dr Meaney is dedicated to making top quality care as cost effective as possible. To assist you with your dental care investment we provide the following payment options.

1. CASH OR PERSONAL CHECK
2. VISA/MASTERCARD, DISCOVER OR AMERICAN EXPRESS
3. CARECREDIT THE MONTHLY PAYMENT PLAN WE OFFER AS A SEPARATE LINE OF CREDIT TO COVER YOU FAMILY'S DENTAL CARE NEEDS.

We will submit to your insurance company, however co-payments are due at the time of treatment. If for any reason your insurance company does not pay, you will be responsible for the balance. If you do not have dental insurance payment in full is expected at the time of treatment.

If after 30 days a balance or co-payment are not paid, 1% of the balance will be charged as a monthly billing fee.

If CareCredit is your preferred option, you many begin any treatment immediately and spread the payment over time.

◯ Yes ◯ No

Relationship to Patient:

Signature: ____________________

Date:

Response Date: