



Welcome to Our Office

Please complete the following information so that we may better serve you.

Date: _____

PATIENT INFORMATION

Title: Mr. Mrs. Ms. Miss Dr. Legal Name: _____ Male Female

Preferred Name: _____ Birthdate: _____ Marital Status: _____

Address: _____ City: _____ St: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-Mail: _____ SSN: _____ - _____ - _____

Employer: _____ Occupation: _____

If Patient is a Minor, Give Responsible Party's Name: _____

Relationship to Patient: _____

How did you hear about our Practice? _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance (if applicable)
Subscriber Name: _____	Subscriber Name: _____
Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Subscriber ID/SSN: _____	Subscriber ID/SSN: _____
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Insurance Company: _____	Insurance Company: _____
Group #: _____	Group #: _____

EMERGENCY NOTIFICATION INFORMATION

Primary Care Physician: _____ Phone: _____

In case of an emergency, who should be notified?

Name: _____ Phone: _____ Relationship: _____

Health History

Printed Name: _____

Oral Care Habits: Toothbrush: Regular or Electric Floss: Regular/Hydrofloss/Waterpik/None Mouth Rinse:

Please answer these Questions about your Dental Health (please check if YES)	
<input type="checkbox"/> Gums bleed when brushing/flossing	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Teeth Sensitive to Hot or Cold	<input type="checkbox"/> Clench or Grind Teeth
<input type="checkbox"/> Pain in teeth? Where?	<input type="checkbox"/> Orthodontic Braces now or in Past
<input type="checkbox"/> Clicking, Pain, Discomfort or Difficulty opening Jaw	<input type="checkbox"/> Dental visits make you anxious

Please Describe reason for you visit: _____

Have you been in the hospital in the past 2 years? YES NO Explain: _____

Current or Former Smoker? YES NO Packs/day _____ For how long? _____ Quit Date: _____

Current or Family History of Diabetes? YES NO Self/Mother/Father Type I or Type II Current A1C: _____

Current or Previous treatment for Osteoporosis/Bone Cancer? YES NO

Oral/IV treatment with: Boniva Fosamax Zometa

If YES, which medication and Why? _____

Do you have any prosthetic device (e.g. heart valve or stent, artificial joint, implant, pacemaker, etc) YES NO

Do you require a Pre-Medication of antibiotics before dental procedures as ordered by a physician? YES NO

If YES, which antibiotic do you currently take? _____

FEMALES: Are you pregnant? YES NO

Are you allergic or sensitive to any medicine, dental anesthetic or latex products? YES NO

If YES, to what? _____

Prescription Medications or over-the-counter medications: (attach separate sheet if needed)

Medication and Dosage	Why taking:
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Do you have now or have you ever had any of the following diseases or medical conditions?

- | | | |
|--|--|---|
| <input type="checkbox"/> Increased Urination | <input type="checkbox"/> Difficulty Laying Back in Chair | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Palpitations/Arrhythmia |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Eye/Vision Disorders | <input type="checkbox"/> Panic Attacks/Phobias |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss/Ear Problems | <input type="checkbox"/> Psychiatric Treatment/Depression |
| <input type="checkbox"/> Bisphosphonates/Osteoporosis | <input type="checkbox"/> Heart Disease/Heart Attack/MI | <input type="checkbox"/> Recent Weight Gain or Loss |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer/Malignancies | <input type="checkbox"/> Heart Surgery/Angioplasty/Stent | <input type="checkbox"/> Seizures/Epilepsy/Convulsions |
| <input type="checkbox"/> Chemo/radiation therapy | <input type="checkbox"/> Hemophilia/Prolonged Bleeding | <input type="checkbox"/> Severe Headaches/Dizziness |
| <input type="checkbox"/> Chest Pain/Angina Pectoris | <input type="checkbox"/> Hepatitis A, B or C/Liver Disease | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Colitis/Crohn's/Intestinal Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chronic Tiredness/Fatigue | <input type="checkbox"/> High Fear of Dentistry | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Coronary Artery Disease/Bypass | <input type="checkbox"/> Kidney, Bladder Problems/Dialysis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Diabetes/High Blood Sugar | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Weakness/Tingling/Numbness |

Any additional information (disease, condition or problem not listed) we should know? YES NO

If Yes, Explain _____

To the best of my knowledge, the information I have given is true and correct. I understand that this will be held in confidence and it is my responsibility to inform Meyer Family Dentistry of any future changes in my medical status.

Signature of Patient, aren't or Guardian: _____ Date: _____

Relationship to Patient: Self Parent Guardian Other: _____

Meyer Family Dentistry

Rodney A. Meyer, DDS, LLC

Financial Policy

The primary goal of our office is to provide you with the quality dental care you need. We will strive to make this as affordable as possible.

Please understand that your dental insurance was not created to pay for all your dental care needs. Unlike health insurance, dental insurance was created to assist with the costs of some preventative treatment needs; x-rays, simple cleanings, simple fillings, etc... We will assist you with your benefit eligibility before treatment to help calculate patient responsibility. This payment is due at the time of service.

We accept payment in the form of Cash, Check and Credit Card

Insurance

Meyer Family Dentistry provides insurance company billing as a courtesy to our patients. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely solely upon any information provided by Meyer Family Dentistry staff regarding his/her remaining benefit in any such benefit period. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

Delinquent Payments

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25.00

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed hygiene and doctor exam appointments at the rate of \$50.00 per appointment at the discretion of Meyer Family Dentistry. Please help us service you better by keeping scheduled appointments.

I have read and agree to the Financial Policy and the Cancellation Policy of Meyer Family Dentistry.

Signature of Patient or Responsible Party: _____

Date: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of you protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent
- Photos will often be taken of your case to be submitted for insurance purposes and occasionally used for marketing and education purposes.

May we phone, email or send a text to you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we discuss your medical condition with any member of your family	Yes	No

If Yes, please name the members allowed:

This consent was signed by: _____
(Print Name)

Signature: _____ Date: _____

Witness: _____ Date: _____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize
Dr. Rodney A. Meyer DDS and staff, to take photographs, and/or videos of my
face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Marketing material, including websites and printed materials, patient education
- I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
- I do not expect compensation, financial or otherwise, for the use of these photographs.
- Check here if you do not want your full face shot used for any of the above purposes

- Signature (Patient) _____
- Date _____