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: □ Self □ Spouse□ Child □ Other	Relationship to Subscriber: □ Self □ Spouse□ Child □ 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)	
□ Gums bleed when brushing/flossing	□ Frequent Headaches
□ Teeth Sensitive to Hot or Cold	□ Clench or Grind Teeth
□ Pain in teeth? Where?	□ Orthodontic Braces now or in Past
□ Clicking, Pain, Discomfort or Difficulty opening Jaw	□ Dental visits make you anxious

Please Describe the reason for your visit:____
____
____

Is there anything you'd like to change about your smile? Please explain:
____
____

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

□ Increased Urination
□ Increased Thirst
□ Allergies
□ Aneurysm
□ Arthritis
□ Asthma
□ Bisphosphonates/Osteoporosis
□ Blood Transfusion
□ Cancer/Malignancies
□ Chemo/radiation therapy
□ Chest Pain/Angina Pectoris
□ Colitis/Crohn's/Intestinal Problems
□ Chronic Bronchitis
□ Chronic Tiredness/Fatigue
□ Congenital Heart Defect
□ Coronary Artery Disease/Bypass
□ Diabetes/High Blood Sugar
□ Difficulty Laying Back in Chair
□ Drug Addiction/Alcoholism
□ Emphysema
□ Eye/Vision Disorders
□ Fainting/Dizziness
□ Hearing Loss/Ear Problems
□Heart Disease/Heart Attack/MI
□ Heart Murmur
□ Heart Surgery/Angioplasty/Stent
□ Hemophilia/Prolonged Bleeding
□ Hepatitis A, B or C/Liver Disease
□ High Blood Pressure
□ High Cholesterol
□ High Fear of Dentistry
□ HIV+/AIDS
□ Kidney, Bladder Problems/Dialysis
□ Mitral Valve Prolapse
□ Pacemaker
□ Organ Transplant
□ Palpitations/Arrhythmia
□ Panic Attacks/Phobias
□ Persistent Cough
□ Psychiatric Treatment/Depression
□ Recent Weight Gain or Loss
□ Rheumatic Fever
□ Seizures/Epilepsy/Convulsions
□ Severe Headaches/Dizziness
□ Sexually Transmitted Disease
□ Shortness of Breath
□ Sinus Problems
□ Stroke/TIA
□ Thyroid Problems
□ Tuberculosis (TB)
□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, Parent 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 your 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.
- ☐ Please check if you do not authorize photos to be used for any of the above purposes.

We will take a photo to be used for your file only

- Signature (Patient) ________________________________
- Date ___________