Meyers Family
Dentistry

Patient Registration

Full Name_____Age_____

Social Security Number_____ Date of Birth_____ Sex_____

Billing Address_____ City_____ State_____ Zip_____

Home address (if different from above)_____ City/State/Zip_____

Day phone_____ Home Phone_____ Email address_____

Driver license number/ID number_____ State of issue_____

Primary Care Provider_____ Phone Number_____

Preferred Pharmacy_____ Phone Number_____

Employer_____ Phone Number_____

Emergency contact/relationship_____ Phone Number_____

Previous Dentist_____Phone Number_____

Referred by_____ Marital Status_____

Name of Primary Insurance_____ Policy Number_____

Policyholder Name_____ Social Security Number_____

Date of Birth_____ Relationship to Patient_____

Name of Secondary Insurance_____ Policy Number_____

Policyholder Name_____ Social Security Number_____

Date of Birth_____ Relationship to Patient_____

Minor Patients Only

Mother's Name_____ Address _____

Employer_____ Date of Birth_____

Social Security Number_____ Phone_____

Father's Name_____ Address_____

Employer_____ Date of Birth_____

Social Security Number_____ Phone_____

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Patient Name_____ DOB_____ Chart #_____

Circle Appropriate Answer (leave blank if you do not understand the question)

Yes No is your general health good?
Yes No Has there been a change in your health in the last year?
Yes No Are you under the care of a physician? If Yes Name and Phone_____
If yes, what condition is being treated _____
Date of last medical exam_____
Yes No Have you been hospitalized or had a serious illness in the last three years _____
If yes, Please explain_____
Yes No Have you had problems with prior dental treatment_____ Date of last exam_____
Yes No are you in pain now? Describe_____

Do You Have or Have you Had:

Yes No bleeding problems, bruising easily
Yes No Sinus problems
Yes No Stroke, Hardening of Arteries
Yes No Heart Disease
Yes No Heart Attack, Heart Defects
Yes No Blood Transfusions
Yes No Heart Murmur
Yes No Prosthetic Heart Valve
Yes No Pacemaker
Yes No Rheumatic Fever
Yes No High Blood Pressure
Yes No Artificial Joint
Yes No Stomach Problems, Ulcers
Yes No Psychiatric Care

Yes No Thyroid, Adrenal Disease
Yes No Diabetes
Yes No Seizures
Yes No Dry Mouth
Yes No HIV or AIDS
Yes No Tumors or Cancer
Yes No Radiation Treatments
Yes No Chemotherapy (pills and/or injections)
Yes No STD _____
Yes No Arthritis, Rheumatism
Yes No Asthma, TB, Emphysema, other lung disease
Yes No Hepatitis, other Liver Disease
Yes No Kidney or Bladder Disease
Yes No Osteoporosis

Are You Taking:

Yes No Recreational Drugs
Yes No Alcohol, Beer or Wine
Yes No Tobacco (Pipes, Cigars, Cigarettes, Chew, Smokeless)
____ packs per Day X _____Years
Yes No Drugs, Medications or over the counter medications (including Aspirin), Natural Remedies:
Please List_____

Women Only:

Yes No Birth control Method
Yes No Are you pregnant or Nursing?

All Patients

Yes No Do you have or have you had any other diseases or medical problems not listed above?
If yes, Please explain_____
Yes No Allergies to: Drugs, Foods, Latex,_____

- To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medications. Initial_____

Signature of Patient or Guardian_____ **Date**_____ **Updated**_____
Signature of Dentist_____ **Date**_____ **Updated**_____
Hygienist Initials_____

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Notice of Privacy Practices Acknowledgment

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Acknowledgement and Consent

I understand that Merys Family Dentistry will use and disclose health information about me.

I understand that my health/dental information may be include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health/dental status symptoms, examination, test results, diagnoses, treatment, procedures, prescriptions, and similar types of health/dental-related information.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding protected health information.

I understand and agree that this practice (Meyers Family Dentistry) may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health/dental care providers for my health information to insurance companies or others who may be responsible to pay for some or all of my dental care; and
- Perform various office, administrative, and business functions that support my dentist's efforts to provide me with, arrange and be reimbursed for quality, cost effective dental care.
- Appointment Reminders- We may call, write, e-mail or text to remind you of scheduled appointments, or that it is time to make an appointment. We may also call, write, or e-mail to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine, cell phone or with someone who answers your phone if you are not home.

I also understand that I have the right to receive and review a written description of how this practice (Meyers Family Dentistry) will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of this practice and my right regarding my health information.

I understand that the notice of privacy practices may be revised from time to time, and that I am entitled to receive a copy of any revised notice of privacy practices. I also understand that a copy or summary of the most current version of the practice's notice of privacy practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

By signing below, I agree that I have received and understand the information above and that I have received a copy of the notice of privacy practices.

Patient Name:

Relationship to patient:

Date:

Signature:

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Financial Policy

Thank you for choosing Meyers Family Dentistry, as your dental provider. We are committed to providing excellent, ethical, and compassionate care in a comfortable atmosphere. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Payment for services is due at the time the services are rendered, including any dental insurance deductible and/or estimated portion. We accept cash, check, Discover, American Express, Visa, and MasterCard.

If you have dental insurance, we will be happy to process your insurance claim for you. We emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges not paid by your insurance carrier are your responsibility.

We will make every effort to contact your insurance company at your appointment to determine what your estimated co-pay will be. This will be done on your first visit only. If it cannot be determined, we will require 20% to 50% of our fee to be paid when treatment is rendered depending on the type of service. When the insurance payment is received, if there is a credit, a refund will be sent to you promptly. If there is an additional amount due, we will send a statement for the balance that will then be immediately payable in full. It is the responsibility of the patient, not the provider to know what is covered and what is excluded from his/her plan.

I accept full financial responsibility for all charges whether or not they are covered by insurance.

I hereby authorize payment to Myers Family Dentistry of the group insurance benefits otherwise payable to me. I also authorize release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company. If it becomes necessary to employ collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all cost and expenses including reasonable attorney fees.

I hereby authorize Meyers Family Dentistry to administer any treatment and to administer such x-rays, anesthetics, and dental procedures as may be deemed necessary or advisable in diagnosis and treatment of dental conditions that doctor discusses with me. I understand treatment and the use of anesthetic agents embodies a certain risk.

This office is NOT a part of your general judgment (divorce decree). The accompanying adult is solely responsible for full payment regardless of what your general judgment may state. Any minor child must be accompanied by a parent or legal guardian.

We reserve the right to apply a finance charge/billing charge in the amount of 0.5% per month or 18% annually or a $200.00 billing charge to all balance after 90 days as allowed by state law. A fee of $25.00 will be assessed to your account for any check returned unpaid by our bank.

Authorization

I authorize the release of medical and dental information including photographs to insurance carriers and to other health care providers involved in the care of this patient. These records may be used by Meyrs Family Dentistry for teaching purposes, scientific publication, social media, advertising and credit bureau reports as necessary. In the future, please advise doctor of any changes to your medical or dental health while under the care of our office. Cell phone and carrier information is used to confirm appointments. Thank you.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help.

Signature: Date:

COVID-19 Patient Screening Form

Patient Name: Age:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you have a fever or have you felt feverish recently?	☐ Yes ☐ No	☐ Yes ☐ No
Are you having shortness of breath, other difficulties breathing or a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been tested for COVID-19 or had an antibody test?	☐ Yes ☐ No	☐ Yes ☐ No
Are you in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled outside the US by air or cruise ship in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled within the US by air, bus or train within the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion before proceeding with elective dental treatment.