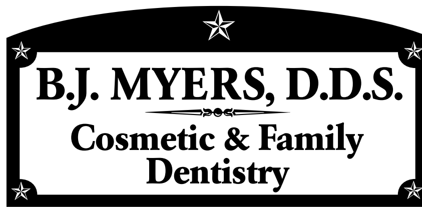

Name ____________________ Email ____________________ Date __________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Address ____________________ City ____________________ Zip __________

Social Security # ____________________ Date of Birth ____________________ Age __________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation ____________________ Employer Name ____________________ Bus. Phone ____________________

Business Address ____________________ City ____________________ Zip __________

Spouse's Name ____________________ Social Security # ____________________

Spouse's Occupation ____________________ Employer Name ____________________ Bus. Phone ____________________

Person to Contact in an Emergency ____________________ Relationship ____________________

Phone (Home) ____________________ (Work) ____________________

Party Responsible for Payment of Account ____________________

PHONE (HOME) ____________________ (Work) ____________________

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

	- PRIMARY CARRIER -	- SECONDARY CARRIER -
Insurance Co.	____________________	____________________
Policy No.	____________________	____________________
Insurance Co. Address	____________________	____________________
Phone	____________________	____________________

Whom may we thank for referring you? ____________________ Reason for this visit ____________________

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas which pertain to you.

- ALL INFORMATION IS PRIVATE AND CONFIDENTIAL -

• DENTAL HISTORY

Date of Last Visit ____________________ Date of Last Cleaning ____________________ Last F.M. X-Rays __________

Check any of the following you have had/currently have:

- ☐ Mouth Discomfort
- ☐ Previous Periodontal Treatment
- ☐ Trenchmouth or Pyorrhea
- ☐ Gum Abcesses
- ☐ Gums Bleed When Brushing
- ☐ Loose or Shifting Teeth
- ☐ Trouble in Chewing or Speaking
- ☐ Bruise Easily
- ☐ Grind or Clinch Your Teeth
- ☐ Clicking, Popping or Pain in Jaw Joints
- ☐ Orthodontic Treatment
- ☐ Sensitive Teeth (Heat, Cold, or Sweets)
- ☐ Awake with Sore Jaw
- ☐ Mouth Odor or Bad Taste
- ☐ Cold Sores or Fever Blisters
- ☐ Other Oral Lesions
- ☐ Fear of Dental Treatment
- ☐ Bad Dental Experience
- ☐ Had Immediate Relatives Lose All of Their Natural Teeth
- ☐ Complications with or Following Previous Dental or Oral Surgical Treatment
- ☐ Other ____________________

MEDICAL HISTORY

PATIENT NAME ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No ○ N/A ______________________________

Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ N/A ______________________________

Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A ______________________________

Are you taking any medications, pills, or drugs? ○ Yes ○ No ○ N/A ______________________________

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ○ N/A

Do you use tobacco? ○ Yes ○ No ○ N/A

Are you on a special diet? ○ Yes ○ No ○ N/A

Do you use controlled substances? ○ Yes ○ No ○ N/A

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other ______________

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness or injury not listed above? ○ Yes ○ No ○ N/A

Comments: ______________________________

____

____

____

____

* Condition may require medication   N/A- Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN   DATE

B.J. Myers, D.D.S.
Cosmetic & Family Dentistry

I. Financial Policy

At all of your visits you will be responsible for the estimated amount insurance will not cover plus any deductible. When the actual benefits are received from the insurance company, your account will be adjusted accordingly. Each plan is different, but in general, insurance usually covers about 70% of simple care and 50% of major work. Please be aware that you will be ultimately responsible for payment of dental services regardless of the amount the insurance company pays.

Because we understand the value of insurance benefits to our patients, we will be happy to complete and file your insurance forms at no charge. We will also be happy to work with your insurance company to maximize the benefits you receive from your plan. If you have any questions about your account, we will be happy to answer them or let you know about your current account balance. We accept, cash, check, money orders, Visa, Master Card, Discover and American Express for payment.

I ____________________________________ understand that I am responsible for all fees regardless of insurance coverage. I also understand that as treatment progresses the above fees may have to be adjusted. In the event that my insurance does not fully cover my estimated portion, I will be responsible for the remaining balance. Any account with a balance 30 days past due will be subject to a finance charge of 0.83% (minimum of $1.00). In the event that my payments are not received within 60 days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

II. Cancellation Notice

If you must re-schedule your appointment, we require 24 hours notice or there will be a fee of $35 per hour of scheduled time charged to your account.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing.

8430 Spicewood Springs Road ● Austin, TX 78759 ● Phone (512) 506-9430 ● Fax (512) 506-9330

B.J. Myers, D.D.S.
Cosmetic & Family Dentistry

I hearby consent to the procedures and protocol of this office.

____
Signature of patient or parent/guardian if minor **date**

____
Interpreter (if used) **date**

____
Signature of Witness **date**

Acknowledgement of Notice of Privacy Practices

____
Print Name

____
Signature **date**

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____Patient refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (please describe)

Dentist Certification

I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives (including no treatment and attendant risks), of the proposed procedure(s). I have offered answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

Dentist's signature ____
Print Name ______________________________ date ____________

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B.J. Myers, D.D.S.
Cosmetic & Family Dentistry

Consent Form for Dental Treatment

Dr. Myers has fully explained to me the purpose of the procedure(s) and has also informed me of expected benefits and complications (from known and unknown causes) including but not limited to bleeding, infection, numbness, swelling, tooth damage, root canal therapy, and nerve exposure requiring referral to a dental specialist, attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the procedure(s).

____
Print Name

____
Signature **date**

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