TIME 10:11 AM DATE 11/8/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact Name

Relationship

Emergency Phone #

Appt.Text Reminder

Referral Source:

...

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Medical History Form Dr. Alan Myers

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Herpes Yes No	Rheumatic Fever Yes No	Angina Yes No
Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No	Epilepsy or Seizures Yes No
High Cholesterol Yes No	Scarlet Fever Yes No	Artificial Heart Valve Yes No	Excessive Bleeding Yes No
Shingles Yes No	Artificial Joint Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Kidney Problems Yes No	Spina Bifida Yes No	Blood Transfusion Yes No
Leukemia Yes No	Stomach/Intestinal Disease Yes No	Breathing Problems Yes No	Liver Disease Yes No
Stroke Yes No	Bruise Easily Yes No	Low Blood Pressure Yes No	Cancer Yes No
Glaucoma Yes No	Thyroid Disease Yes No	Chemotherapy Yes No	Hay Fever Yes No
Mitral Valve Prolapse Yes No	Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No
Tuberculosis Yes No	Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No
Tumors or Growths Yes No	Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	

Have you ever had any serious illness not listed above?	Yes No	If yes

Comments:

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:

X Date:_____

Patient Name: _____ DOB: _____

Patient Dental History

Name of Previous Dentist and Location:

_____ Date of Last Exam: _____

		Yes	No
1.	Do your gums bleed while brushing?	( )	( )
2.	Are your teeth sensitive to hot or cold liquids/foods?	( )	( )
3.	Are your teeth sensitive to sweet or sour liquids/foods?	( )	( )
4.	Do you feel pain to any of your teeth?	( )	( )
5.	Do you have any sores or lumps in or near your mouth?	( )	( )
6.	Do you have any head, neck or jaw injuries?	( )	( )
7.	Have you ever experienced any of the following problems in your jaw?		
	Clicking	( )	( )
	Pain (joint, ear, side of face)	( )	( )
	Difficulty in opening or closing	( )	( )
	Difficulty in chewing	( )	( )
8.	Do you have frequent headaches?	( )	( )
9.	Do you clinch or grind your teeth?	( )	( )
10.	Do you bite your lips or cheeks frequently?	( )	( )
11.	Have you ever had any difficult extractions in the past?	( )	( )
12.	Have you ever had any prolonged bleeding following extractions?	( )	( )
13.	Have you had any orthodontic treatment?	( )	( )
14.	Do you wear dentures or partials?	( )	( )
	If yes, date of placement: _____		
15.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	( )	( )
16.	Do you like your smile?	( )	( )

17. Why did you leave your last dentist?

_____

18. What did you like most about any dentist you've ever been to in your life?

_____

19. What did you like least about any dentist you've ever been to in your life?

_____

20. What are you expecting to have done?

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments

_____

_____

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Patient Signature/Date: _____

Print Name: _____

OR

Personal Representative Signature/Date: _____

Print Name: _____

Authority of Personal Representative to Sign for Patient (check one):

( ) Parent ( ) Guardian ( ) Power of Attorney ( ) Other: _____

Please Note: It is your right to refuse to sign this Acknowledgment.

Dental Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) An emergency prevented us from obtaining acknowledgment.
( ) A communication barrier prevented us from obtaining acknowledgment.
( ) The individual was unwilling to sign.
( ) Other: _____

_____ Date: _____

Staff Member Signature

581 Furys Ferry Road
Furys Ferry Town Center
Martinez, Georgia 30907
Phone: (706)738-7742 Fax: (706)738-9411
MyersFamilyDental@gmail.com
www.MyersDMD.com

Request and Authorization for Release of Records and/or X-rays

I, _____, hereby authorize the doctors and staff of
(Patient Name)

_____to release records, x-rays or knowledge
(Dr. or Practice Name)

concerning my dental health to:

Myers Family Dental
581 Furys Ferry Road
Furys Ferry Town Center
Martinez, Georgia 30907
Phone: (706)738-7742 Fax: (706)738-9411
MyersFamilyDental@gmail.com
www.MyersDMD.com

Please email all digital x-rays to myersfamilydental@gmail.com

Signed: _____ Dated: _____
(Patient or Guardian Signature)