Stephen C. Myers DMD, PA
COSMETIC, RESTORATIVE, AND GENERAL DENTISTRY

WELCOME
TO OUR PRACTICE

It is our pleasure to welcome you to our practice. Please fill out this form as completely as possible so that we may get to know you and serve your dental needs. We will be happy to help you with any questions if you need assistance.

Name ______________________________ Preferred ______________________________

Address ______________________________ City ______________________ State ______ ZIP ____________

Sex: ( ) Male ( ) Female Status: ( ) Married ( ) Single ( ) Widowed ( ) Minor Date of Birth _____/_____/_________

Email ______________________________ Employer ______________________ Occupation ______________________

Home Phone ______________________ Cell ______________________ Work ______________________ EXT ________

As a courtesy to you, we will confirm your appointments. What is the best method to contact you? Text ( ) Email ( ) Cell ( ) Home ( )

Whom may we thank for referring you? ______________________________

In case of emergency, who should we contact? ______________________ Phone (_____)____________ Relationship ______________

RESPONSIBLE PARTY INFORMATION FOR FINANCIAL ACCOUNT

(IF FINANCIAL ACCOUNT INFO IS DIFFERENT FROM THE PATIENT INFORMATION ABOVE)

Name: ______________________ Relationship: ______________ Social Security # ______________________ DOB ____________

Home Phone ______________________ Cell ______________________ Work ______________________

Address ______________________________ City ______________________ State ______ ZIP ____________

PRIMARY DENTAL INSURANCE

Insured Party ______________________ Relationship ______________________ Employer ______________________

Subscriber's SS# ______________________ Telephone ______________________ Birthday ______________________

Address ______________________________ City ______________________ State ______ ZIP ____________

Plan Name ______________________ Ins. Co. Name ______________________

Ins. Company Address ______________________________ Ins. Company Telephone ______________________

ID# ______________________________ Group # ______________________

MEDICAL HISTORY

Are you currently under the care of a physician? [ ]Yes [ ]No Physician's Name: ______________________ Phone # ______________________

For what condition are you being treated? ______________________________

Have you ever been treated for cancer with radiation or chemotherapy? [ ]Yes [ ]No If so when and what area? ______________________

Are you allergic to medications, latex gloves, local anesthetics, etc.? ________ List allergies ______________________

Please list any other medical problems you may have or have had in the past ______________________

Pharmacy of choice: ______________________ Pharmacy Phone # ______________________

Does your medical history include any of the following conditions?

[ ] AIDS	[ ] Anemia	[ ] Arthritis	[ ] Artificial joints	[ ] Blood disease
[ ] Cancer	[ ] Diabetes	[ ] Dizziness	[ ] Excessive bleeding	[ ] Epilepsy
[ ] Fainting	[ ] Glaucoma	[ ] Hay fever	[ ] Head injury	[ ] Heart Murmur
[ ] Hepatitis	[ ] High blood pressure	[ ] Jaundice	[ ] Kidney disease	[ ] Liver disease
[ ] Mental disorders	[ ] Nervous disorders	[ ] Pregnant	[ ] Radiation treatment	[ ] Respiratory problems
[ ] Sinus problems	[ ] Stomach problems	[ ] Stroke	[ ] Tuberculosis	[ ] Tumors

[ ] Other ______________________________

Medications you are currently taking: ______________________________

DENTAL HISTORY

What dental problems you would like addressed? ____

Which do you consider most important? ___Preserving natural teeth ___Eliminate pain ___Appearance of your smile ___Eliminate infection

What is your reaction to having dental treatment? ___Enjoy the experience ___Do not mind it ___Dread it ___Worry about it

When was your last dental appointment? ____________________ Purpose of last dental appointment? ________________________

How often do you brush your teeth? ____________________ What do you use to clean between your teeth?______________________

What texture of toothbrush? __ Soft __Med. ___Hard Do you use an electric or manual toothbrush? ________________________

How would you rate your smile? (1 – 10,1 is worst) ____________ Would you like your teeth to be whiter? Yes No

Please check any of the following habits, conditions or concerns you have:

[ ] bleeding gums	[ ] missing permanent teeth	[ ] appearance of teeth	[ ] sensitive teeth
[ ] facial muscle pain	[ ] tender or swollen gums	[ ] clinch or grind teeth	[ ] existing cavities
[ ] tired jaws	[ ] broken teeth or fillings	[ ] frequent headaches	[ ] gag easily
[ ]"sweet tooth"	[ ] history of gum surgery	[ ] chew hard crunchy foods	[ ] chew ice

[ ] history of radiation or chemotherapy for cancer related problems

Please add anything you feel is important that will help us serve you better:______________________________________

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OFFICE POLICIES AND CONSENT

1. I hereby authorize the Doctor to take necessary x-rays, study models, photographs, or any other diagnostic aid deemed appropriate.
2. I understand that quality dental care is often a result of several professionals, both general dentists and specialists, working together as a team to provide the best care for the patient. I understand this form and all information may be shared.
3. I understand that each appointment scheduled is time specifically reserved and in the event of any changes I will give the office a minimum of 48 hours notice.
4. I understand the use of anesthetic agents embodies a certain level of risk.
5. In case of a medical emergency, I authorize the Doctor to perform any and all forms of treatment, medications and therapy that may be indicated and further authorize the Doctor to choose and employ such assistance as he deems fit.
6. The patient is fully responsible for all fees incurred. Fees are due and payable at the time services are rendered.
7. I understand that a 1.5% per month charge (18% annually) will be added to any overdue balance. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required to effect collection of this note.
8. Patients with Dental Insurance: I understand that dental insurance is a contract between the patient and the insurance company and not between the insurance company and the doctor. All professional services rendered are charged to the patient and they are personally responsible for payment of all fees. Please remember that insurance is considered a method of reimbursing the patient for fees charged and is not a substitute for payment. Some companies pay fixed allowances for procedures, others pay a percentage of fees and some send payment only to the patient. To determine the method of reimbursement by your insurance company, we ask that you pay for your initial appointment. For subsequent appointments your estimated portion, not covered or paid by insurance, is due at time services are rendered. It is your responsibility to pay any deductible amounts or any balance not paid for by your insurance company.

This signature on file is my authorization for the release of information to process my claim.

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Signature of Patient (Parent or Guardian if minor)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. In the event of a change in the above information, I will inform this office so that my records can be updated. I have read the consent and office policies above and agree and will abide with the content.

____ ____________________

Signature of Patient (Parent or Guardian if minor) Date