B.J. MYERS, D.D.S. & Associates

Cosmetic & Family Dentistry

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 Number(s) _____ _____

Party Responsible for Payment of Account _____ Relationship _____

Phone Number(s) _____ _____

How did you find out about our office? _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

	- PRIMARY CARRIER -	- SECONDARY CARRIER -
Insurance Co.	_____	_____
Group #	_____	_____
Id #	_____	_____
Insurance Co. Address	_____	_____
Phone	_____	_____

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

Reason for this Visit _____

_____

_____

☐ 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	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	○ N/A	
Are you on a special diet?	○ Yes	○ No	○ N/A	

Do you use tobacco? ○ 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 ☐ Sulfa ☐ 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

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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. However, we do not file secondary insurances. We will print out the forms you will need if you have two insurance policies and explain what you should do from there. 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, MasterCard, Discover, American Express and Care Credit for payment. You can also view and pay your balance at www.smiledash.com.

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 90 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. (Please note, any Monday appointments need to be addressed no later than Friday.)

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

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

→ _____

Signature of patient or parent/guardian if minor date

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

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Notice of Privacy Practices is posted on laminated sheet attached to New Patient forms. If you would like to receive a paper copy for your personal records, please ask one of our front office team members, and they would be happy to assist you.

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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Consent Form for Dental Treatment

The dentist 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. 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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