

PATIENT REGISTRATION

Please complete the following confidential information.

Full Name Preferred Name Today's Date

Spouse Other Family Member's in Practice

Address City State Zip

Mailing Address (If Different from Above) City State Zip

() _____ () _____ () _____
Home Phone Work Phone (including ext) Mobile Phone E-mail Address

Date of Birth Marital Status Social Security Number Driver's License Number

Person to Contact in Case of Emergency () _____ () _____
Home Phone Work Phone

Relative or Friend NOT Living with You: _____

Address City State Zip

EMPLOYMENT INFORMATION

Name of Employer (If Student, Name of School) Occupation

Address City State Zip

Name of Spouse's Employer (If Applicable) Occupation

Address City State Zip

INSURANCE INFORMATION

Primary Dental Insurance Carrier Insured's Name ID Number Date of Birth

Employer Name Group Number Effective Date Relationship to Patient

Secondary Dental Insurance Carrier Insured's Name ID Number Date of Birth

Employer Name Group Number Effective Date Relationship to Patient

Whom May We Thank for Referring You? _____

PLEASE SIGN BACK OF FORM

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

ACKNOWLEDGMENT OF PRIVACY PRACTICE NOTICE

I the undersigned, acknowledge that I have read and/or received a Notice of Privacy Practice from Eric Meyer, DDS.

Patient's Signature _____ Date _____

MEDICAL HISTORY

Are you currently under the continuous care of a medical doctor?.....Yes No

If yes, for what? _____

Physician's name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Are you taking any medication, drugs, or pills now?.....Yes No

Are you aware of having any allergic (or adverse reaction) to any medication?.....Yes No

If yes, please list _____

Please circle yes or no to the following list if you have had or have at present.

- | | | | | | |
|---|-----|----|---------------------------------------|-----|----|
| Cancer..... | Yes | No | Glaucoma..... | Yes | No |
| Stroke..... | Yes | No | Emphysema..... | Yes | No |
| A.I.D.S..... | Yes | No | Tuberculosis..... | Yes | No |
| H.I.V..... | Yes | No | Asthma..... | Yes | No |
| Blood Transfusion..... | Yes | No | Latex Sensitivity..... | Yes | No |
| Hepatitis A (infectious) B (serum)..... | Yes | No | Heart (surgery, disease, attack)..... | Yes | No |
| Epilepsy or Seizures..... | Yes | No | Chest Pain..... | Yes | No |
| Psychiatric/Psychological Care..... | Yes | No | Congenital Heart Disease..... | Yes | No |
| Artificial Joints (hip, knee, etc)..... | Yes | No | Heart Murmur..... | Yes | No |
| Diabetes..... | Yes | No | High Blood Pressure..... | Yes | No |
| Phen Phen Usage..... | Yes | No | Mitral Valve Prolapse..... | Yes | No |
| Do you have or have you had any disease, condition, or problem not listed?..... | Yes | No | Artificial Heart Valve..... | Yes | No |
| If yes, please list _____ | | | Heart Pacemaker..... | Yes | No |
| | | | Rheumatic Fever..... | Yes | No |

Women, are you: Pregnant? Yes _____ months No Nursing? Yes No Taking Birth Control Pills? Yes No

DENTAL HISTORY

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Do you have any dental problems now?.....Yes No

If yes, please describe _____

Are any of your teeth sensitive?.....Yes No

Do your gums bleed or hurt?.....Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner and I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian

Signature _____ Date _____

HISTORY REVIEW

Dentist's Signature _____ Date _____