John Myers, D.D.S., Inc.

Patient Information

(This information is necessary for our files and your health and will be considered CONFIDENTIAL.) Date ____________

Patient's Name ____________ Age ________ Birthday _____ / _____ / _____
Address ____________ City ________ Zip ________

Home# (___) ________ Cell# (___) ________ Work# (___) ________

E-mail ____________ Parent/Guardian (if minor) ________

Social Security# ________ If patient is a full-time student fill in school name ________

Employer ____________ Occupation ________

Employer Address ____________ Work# (   ) ________

Spouse's Name ________ Social Security# ________ Employer ________

Employer Address ____________ Work# (   ) ________

Name of nearest relative not living with you ____________ Relationship ________

Complete Address ____________ Phone # (   ) ________

Has anyone in your family been a patient at our office? Name ____________ Relationship ________

Whom may we thank for referring you? ____________

Responsible Party Information

(If same as above, please ✓❑)

Person responsible for this account ____________ Relationship ________

Address ____________ Home# (___) ________ Cell# (___) ________

Social Security# ____________ Occupation ________

Employer ____________ Work#(___) ________

Employer Address ____________

Spouse's Name ________ S.S.# ________ Occupation ________

Employer ____________ Work# (___) ________ Cell# (___) ________

Employer Address ____________

Dental Insurance Information

Insured Person's Full Name ____________ Insured Birthdate ________ Social Security# ________

Insurance Company Name ____________ Group # ________

Insurance Company Address ____________ Ph.#(___) ________

Employer's Name and Address ____________ Ph.#(___) ________

Do you have OTHER Dental Coverage? ❑ Yes ❑ No (If yes, please complete the following)

Insured Person's Full Name ____________ Insured Birthdate ________ Social Security# ________

Insurance Company Name ____________ Group # ________

Insurance Company Address ____________ Ph.#(___) ________

Employer's Name and Address ____________ Ph.#(___) ________

Medical History

Yes No

❑ ❑ Are you in good health?

❑ ❑ Have you been under the care of a physician during the past two years?

Physician's Name ______________________ Location ______________ Ph# ( ) ________

❑ ❑ Are you sensitive or allergic to any medications or anesthetics?

If yes, please list ____

❑ ❑ Are you now taking any medications? ____________________________________

If yes, please list ____

____

❑ ❑ Do you have, or have you had any of the following? (Please ✓ known conditions.)

- ❑ Heart Failure
- ❑ Heart Disease or Attack
- ❑ Angina Pectoris
- ❑ Arteriosclerosis
- ❑ Congenital Heart Disease
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Rheumatic Fever
- ❑ Arthritis
- ❑ Rheumatism
- ❑ Artificial Joints (hip, knee, etc.)
- ❑ Stroke
- ❑ Epilepsy or Seizures
- ❑ Nervousness
- ❑ Fainting or Dizzy Spells
- ❑ Kidney Trouble
- ❑ Ulcers
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Glaucoma
- ❑ Emphysema
- ❑ Chronic Cough
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Hay Fever
- ❑ Sinus Trouble
- ❑ Allergies or Hives
- ❑ Cancer
- ❑ Tumors
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Venereal Disease
- ❑ H.I.V.
- ❑ Aids
- ❑ Hemophilia
- ❑ Anemia
- ❑ Cold Sores/Fever Blisters
- ❑ Hepatitis A (infectious)
- ❑ Hepatitis B (serum)
- ❑ Bruise Easily
- ❑ Liver Disease
- ❑ Allergy to Latex
- ❑ Developmentally Disabled
- ❑ Weight Control Treatment
- ❑ Drug Addiction
- ❑ Bisphosphonates
  - ❑ Orally
  - ❑ IV

FOR WOMEN ONLY

Are you pregnant? ❑ Yes ❑ No What month? ______________ Are you nursing? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

NOTES (OFFICE USE) ____

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Medical History Update (Office Use)

Date ____________ Signature ____________ Date ____________ Signature ____________

Changes in Health ____________ Changes in Health ____________

Date ____________ Signature ____________ Date ____________ Signature ____________

Changes in Health ____________ Changes in Health ____________

Date ____________ Signature ____________ Date ____________ Signature ____________

Changes in Health ____________ Changes in Health ____________

Date ____________ Signature ____________ Date ____________ Signature ____________

Changes in Health ____________ Changes in Health ____________

Date ____________ Signature ____________ Date ____________ Signature ____________

Changes in Health ____________ Changes in Health ____________

Dental History

Purpose of this visit ____________________

Yes No ____________________

❑ ❑ Are you presently in pain? Where? ____________________

❑ ❑ Are you dissatisfied with the appearance of your teeth? ____________________

❑ ❑ Does food catch between your teeth? Where? ____________________

❑ ❑ Are your teeth sensitive to hot and cold? Where? ____________________

❑ ❑ Do you clench or grind your teeth? Day ❑ Night ❑

❑ ❑ Have you ever had jaw or joint pain? Left ❑ Right ❑

❑ ❑ Do you have any discolorations, growths, or swelling in your mouth? When did it appear? ____________________

❑ ❑ Do your gums bleed when brushing? Where? ____________________

❑ ❑ Do you have any unpleasant odor or taste in your mouth? ____________________

Former Dentist ____________________ Location ____________________ Ph# (__) ____________________

Date of last dental examination ____________________ Were x-rays taken? Yes ❑ No ❑

Date of last cleaning ____________________ What has been your usual interval between cleanings? ____________________

Have you ever received home care instructions? Yes ❑ No ❑

Have you ever had a reaction from a local anesthetic? Yes ❑ No ❑

Have you ever had Endodontia (Root Canal Treatment)? Yes ❑ No ❑

Have you ever had Orthodontic treatment (Braces)? Yes ❑ No ❑

Have you ever had Periodontal Therapy (Gum treatment)? Yes ❑ No ❑

Consent For Treatment

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges. (Visa, Mastercard and Discovery are credit cards accepted by the office.)
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient ____________________ Date ____________________

Parent or Responsible Party ____________________ Relationship to Patient ____________________