B.J. MYERS, D.D.S.
& Associates
Cosmetic & Family Dentistry

Name _____ Date _____

How did you find out about our office? _____ Email _____

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 _____

Business Address _____ City _____ Zip _____

Person to Contact in an Emergency _____ Relationship _____

Phone Number(s) _____ _____

Party Responsible for Payment of Account _____ Relationship _____

Phone Number(s) _____ _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

Name of Insurance Co. _____

Group # _____ Member Id # _____

Insurance Co. Address _____

Phone _____

Are you the policy holder? YES NO If NO, please answer the following:

Policy Holders Name: _____ Policy Holder's Date of Birth _____

Occupation _____ Employer Name _____

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
- ☐ 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 _____

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

Cosmetic & Family Dentistry

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	_____
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	☐ Glaucoma	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Murmur*	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Pace Maker*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ 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

Medications: _____

_____

_____

_____

_____

* 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

MYERS DENTAL
COSMETIC & FAMILY DENTISTRY

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 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 always try our best to work with your insurance company to maximize the benefits you receive from your plan. If you have any questions about your account, please ask for assistance from our friendly front office staff. We accept cash, check, money orders, Visa, Mastercard, Discover, American Express, and Care Credit for payment. You can also pay your balance at www.myersdental.com. You will just need your account number, which we can provide.

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. If insurance overpays, leaving a balance of less than $100.00, the credit will be held on the account for future services or products. Any account with a balance 30 days past due will be subject to a finance charge of 0.83 %. In the event that my payments are not received within 90 days of their due date, I agree to pay all the costs of collections, including but not limited to, reasonable attorney's fees.

Cancellation Policy

If you must reschedule your appointment, we require 24 hours' notice or there will be a fee of $35.00 per hour of scheduled time charged to your account.

I confirm that I have read and fully understand the above. I hereby consent to the procedures and protocol of this office.

_____ _____

Signature Date

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

MYERS DENTAL
COSMETIC & FAMILY DENTISTRY

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

I voluntarily consent to and authorize Myers Dental to use or disclose my health information to the recipient(s) that I identify below:

Recipient 1

Recipient 2

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

B.J. MYERS, D.D.S.
& Associates
Cosmetic & Family
Dentistry

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

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

Notice of Privacy Practices

Dr. BJ Myers, DDS, PA

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Officer.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this NOTICE and to maintain the privacy of your health information. We must also abide by the terms of this NOTICE while it is in effect. We reserve the right to change our privacy practices and the terms of this NOTICE at any time. Before we make significant changes in our privacy practices, we will change this NOTICE and make the new notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement of Receipt of Notice of Privacy Practices.** Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment: Your protected health information will be used to obtain payment for services we provide you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses & Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your health care or with payment for your health care. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.