Meyer Family Dental
4645 S. Midland Dr., Ste. 1
West Haven, UT 84401
801.731.5600

PATIENT REGISTRATION

Patient Name: _____ SSN: _____ Birth date: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____ .

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How do you prefer to be contacted? Cell Phone Home Phone Work Phone Email

Full Time Student? ☐ Yes ☐ NO Name of School: _____ Location: _____

Employer: _____ Email Address: _____

Spouse's Name(If Applicable): _____ Spouse's SSN: _____

Spouse's Birth date: _____ Spouse's Employer: _____ Spouse's Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT
(IF DIFFERENT FROM PATIENT)

Responsible Party's Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ Birth date: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Business Address: _____ Work Phone: _____

INSURANCE INFORMATION

Subscriber Name: _____ SSN: _____ Birth date: _____

Employer: _____ Business Address: _____

Insurance Company: _____ Member ID#: _____

Insurance Company Address: _____

Patient's Relation to Subscriber: Self Spouse Child Have you used your Dental Insurance this benefit year? Yes NO

SECONDARY INSURANCE

Subscriber's Name: _____ SSN: _____ Birth date: _____

Employer: _____ Employee ID#: _____ Relationship to Patient: _____

Insurance Company: _____ Insurance Company Address: _____

*****Insurance is billed as a courtesy to our patients.** We will do everything we can to help you receive your due benefits from your insurance, however, sole responsibility lies with you the patient/responsible party/parent. If your insurance has not paid within a reasonable time, The patient/responsible party is responsible for all charges incurred in this office.

I certify the truth of all personal information contained on this form. I agree to be responsible for payment of services provided. I authorize release of information to my insurance company. I authorize direct payment of my insurance benefits to Dr. Louis W. Meyer for services rendered to me or my dependents. A **FINANCE CHARGE** of 1.5% per month of the unpaid balance (over 90 days) will be added monthly, minimum monthly charge of .50¢. Should collection action become necessary, the responsible party and/or patient agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

Signature: _____ Date: _____

Patient, Parent, Legal Guardian or Authorized Agent

Medical Doctor's Name _____ Phone _____

Please answer the following questions as completely as possible: (circle)

YES NO 1. Are you in pain?

YES NO 2. Do you consider yourself to be in good health?

YES NO 3. Are you now or have you been under a physician's care in the past year?

YES NO 4. Do you take medicine, including birth control? Please specify name and purpose

_____

YES NO 5. Are you pregnant?

YES NO 6. Have you ever had any heart or blood problems?

YES NO 7. Has your physician told you, you have a heart murmur?

YES NO 8. Has your doctor told you to Pre-Medicate prior to dental treatments?

YES NO 9. Do you bleed or bruise easily?

YES NO 10. Have you ever had breathing difficulty such as Emphysema, Chronic cough, pneumonia, Tuberculosis or other lung disorders? If yes what?

YES NO 11. Have you ever had? (check for yes)

☐ Asthma ☐ Diabetes ☐ Liver Disease ☐ Rheumatic fever ☐ Heart Attack
☐ Kidney Disease ☐ Arthritis ☐ Tuberculosis ☐ Hepatitis ☐ Venereal Disease
☐ Immune System Disorders ☐ Rheumatism ☐ Artificial Heart Valve ☐ Any Blood Disorder
☐ Other disease specify ☐ Viral Disease specify: _____

YES NO 12. Have you ever been diagnosed as being HIV positive or having aids?

YES NO 13. Are you allergic to any local anesthetic?
If so please specify: _____

YES NO 14. Are you subject to fainting?

YES NO 15. Have you ever had any reaction to dental treatment or local anesthetics?

YES NO 16. Have you had or do you now have any other serious illness not listed?

YES NO 17. Have you ever had an unusual reaction or are you allergic to any of the following: Penicillin, Aspirin, Acetaminophen(Tylenol), Ibuprofen, Codeine, Barbiturates, Sulfa drugs, Latex,
other: _____

YES NO 18. Do you have any other allergies if yes describe: _____

YES NO 19. Have you ever had a nervous breakdown or undergone psychiatric treatment?

YES NO 20. Have you ever received counseling for use of alcohol and/or prescription drugs?

YES NO 21. Do you think your teeth are affecting your general health in any way?

YES NO 22. Do you have or have you ever had sensitive gums?

YES NO 23. Have you ever taken Phen-fen or similar appetite suppressants?

YES NO 24. If yes have you seen your physician or cardiologist for a cardiac evaluation?

YES NO 25. Have you ever used or are you now using tobacco or alcohol?

YES NO 26. Have you ever had hepatitis or liver disease?

27. How long ago did you see a dentist? _____

YES NO 28. Would you like to change anything about your smile? _____

29. Please add anything you feel is important _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED:

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Meyer and/or such associates assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor and/or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. After lengthy appointments jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled in the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm,if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature _____ Date _____

(Patient, Parent, Legal Guardian or Authorized Agent)

Witness _____ Date _____