

RONALD E. MYERS, D.D.S., F.A.C.P.

I. PATIENT INFORMATION RECORD

Name _____ Age _____ Status _____
Birthdate _____ SS# _____ Drivers License # _____
Address _____
City/State/Zip _____
Home Phone (_____) _____ Work Phone (_____) _____
Whom may we thank for referring you _____

II. EMPLOYMENT INFORMATION

Patient's Employer _____
Employer Address _____
City/State/Zip _____ Phone (_____) _____
Spouse's Name _____ DOB: _____
Spouse's Employer _____
Employer Address _____
City/State/Zip _____
Phone (_____) _____ SS# _____

III. INSURANCE INFORMATION

Insurance Name _____
Address _____
Phone # _____
Policy # _____

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, at the time of service, unless other arrangements are made in advance with the office.

I understand and agree that health insurance policies are an arrangement between an INSURANCE CARRIER AND MYSELF. I understand and agree it is my responsibility to pay any deductible amount, co-insurance, or any other deductible amount, or any other balance not paid for by my insurance.

When charges are filed with your insurance carrier and assignment of insurance benefits is accepted by our office, if the fees are not paid within 60 days, all fees become the patient's responsibility. Our office charges a fee of \$35.00 for any returned check and is subject to the terms below. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. A photocopy of this signature is as valid as the original. I also authorize the doctor to release all information necessary to secure payment.

Signed _____ Date _____

Responsible Party _____ Date _____

PATIENT MEDICAL HISTORY

Yes	No	Have You Ever Had
		Heart Murmur
		Mitral Valve Prolapse
		Stroke
		Heart Disease or Pacemaker
		Heart Surgery
		Rheumatic Fever
		Respiratory Diseases
		Shortness of Breath
		Swelling of Ankles
		High or Low Blood Pressure
		Bleeding Problems
		Artificial Valves in Heart
		Jaundice, Hepatitis, or Liver Disease
		Convulsions
		Dizziness or Fainting
		Diabetes or Insulin-Dependent
		Kidney Disease
		Immune System Problems
		Artificial Joints
		Do You Snore?

Yes	No	Have You Ever Had
		Pain in Chest
		Rheumatism or Arthritis
		Asthma
		Psychiatric Problems
		Cancer
		Radiation or Chemotherapy
		TMJ (Pain in Jaw Joints)
Yes	No	Allergic To
		Penicillin
		Erythromycin
		Aspirin
		Codeine
		Demerol
		Anesthetic, like Novocaine
		Other Drugs or Latex
Yes	No	FEMALES
		Are You Pregnant or Nursing
		Are you using Birth Control Implants or Pills

If you are under the care of a physician at this time, state the nature of your problem:

Please list any pills, shots, or drugs you are taking at this time:

Other Conditions or Problems not listed above:

Work: _____

Who can we contact in the event of an emergency? _____ Home: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient's Signature _____ Date _____	Patient's Signature _____ Date _____
Patient's Signature _____ Date _____	Patient's Signature _____ Date _____
Patient's Signature _____ Date _____	Patient's Signature _____ Date _____
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Doctor's Notes:
