BYERS DENTAL GROUP

Welcome to our office. Our goal is to deliver quality care in a friendly and relaxed atmosphere. This comprehensive care begins with taking necessary x-rays and evaluating your mouth. Our treatment recommendations are based solely upon your health needs, and are designed to restore oral health and prevent future dental problems.

Please help us to understand your primary dental concerns by checking all that apply:

- ⬭ Preventive care to preserve my teeth for life by keeping my teeth and gums healthy
- ⬭ Cosmetic dentistry to improve the appearance of my smile
- ⬭ Only the basic (limited) care offered by my insurance
- ⬭ Emergency care only

Patient referrals are greatly appreciated. Who may we thank for referring you?

_____

Personal Information

Date_____ Date of Birth_____

Name_____

Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

⬭ Male ⬭ Female ⬭ Married ⬭ Single

Emergency Contact_____ Phone_____

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Medical Information

Name of Physician _____ Phone Number _____

Are you currently under treatment? ○ Yes ○ No Reason:_____

Please list all medications (including over the counter, vitamins and herbs) and reason:

Medication/Dosage	Reason

Do you have, or have you ever had, any of the following:

- ○ Heart Disease/Murmur/Attack
- ○ Mitral Valve Prolapse
- ○ Shunts/Stents
- ○ Pins/Plates
- ○ Sinus/Allergy
- ○ Frequent/Severe Headaches
- ○ High/Low Blood Pressure
- ○ Injury to Face/Jaw
- ○ Kidney/Bladder Problems
- ○ Hepatitis/Liver Problems
- ○ Bleeding Problems
- ○ Thyroid Problems
- ○ Seizures
- ○ Cancer
- ○ Pacemaker
- ○ Diabetes
- ○ Rheumatic Fever
- ○ Blood Transfusions
- ○ Stroke
- ○ Tuberculosis
- ○ HIV/AIDS
- ○ Arthritis
- ○ Glaucoma
- ○ Anemia
- ○ Radiation Therapy to Head/Neck
- ○ Steroid Therapy (Cortisone/Hydrocortisone)
- ○ Tobacco Use
- ○ Women Only: Pregnant or Nursing

Allergies/Reaction to:
○ Penicillin ○ Latex ○ Codeine ○ Local Anesthetic
○ Tetracycline ○ Pain Medication ○ Other
Describe reaction: _____
_____

Joint Replacement: Date_____Doctor_____

Told to premedicate/take antibiotics prior to dental visits: ○ Yes ○ No
Doctor's Name: _____
Reason: _____
Medication Taken: _____

Bisphosphonate Drug Therapy (Boniva, Zometa, Reclast, Fosamax, Etc)
Treatment Dates: _____ Delivery Route: ○ Oral ○ IV
Drug Name: _____

Major Illness/Surgery: ○ Yes ○ No Date _____
Describe: _____

Any other health conditions not listed: _____
_____

Print Patient Name: _____Date: _____

Signature of Patient/Guardian: _____

Reviewed By: Staff: _____ Doctor's Initials _____

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Truth in Lending

Payment is due in full the day services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. We also accept Care Credit, an outside financing company, which offers various no-interest payment plans. We do not offer any in-office financing. Patient is ultimately responsible for balance on account, regardless of insurance coverage. Returned checks and balances older than 90 days are subject to additional collection charges, including interest of 1 ½% per month.

Failure to provide us with 48 hour notice for all appointment changes may result in a $60 minimum charge.

Printed Name_____ Date_____

Signature of Patient or Guardian_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I give consent to the doctors' or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed. I understand that I may request a copy of the full Notice of Privacy Practices from this office at any time. I am also aware that I can download a copy from this office's website.

Printed Name_____ Date_____

Signature of Patient or Guardian_____