MyoTech

PATIENT REGISTRATION & MEDICAL / DENTAL HISTORY FORM

Rev. 4/4/2014

Patient: Last Name: _____ First_____ MI ___ Preferred Name _____

Title: Mr/Ms/Mrs: _____ **Gender** □ Male □ Female Family Status □ Married □ Single □ Child □ Other Birth Date: ____/____/____

Email Address_____ Soc. Sec. # __ __ __ - __ __ -__ __ __ __ Driver's.Lic.#_____

Phone: Home (_____) - _____-_____ Work (_____) - _____-_____ Cell: (_____) - _____-_____ Best time to call:_____

Address:_____City:_____ St:____ Zip Code: _____

Whom may be thank for referring you to our Practice?_____

EMPLOYMENT INFORMATION

The following is for □ the patient □ the person responsible for payment

Employer Name: _____ Phone _____

Address:_____City:_____ St:____ Zip Code: _____

PRIMARY INSURANCE INFORMATION

Primary Dental Insurance:

Name of Insured: Last:_____, First _____ Insured's Birth Date:_____

Insured's Address _____ City, _____ St. _____ Zip Code _____

ID# _____ Group #_____

Insured's Employer Name: _____ Address:_____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insurance Plan Name:_____ _____

Insurance Address:_____ City:_____, ST _____, Zip Code _____

SECONDARY INSURANCE INFORMATION

Secondary Dental Insurance:

Name of Insured: Last:_____, First _____ Insured's Birth Date:_____

Insured's Address _____ City, _____ ST. _____ Zip Code _____

ID# _____ Group #_____

Insured's Employer Name: _____ Address:_____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insurance Plan Name:_____ _____

Insurance Address:_____ City:_____, ST _____, Zip Code _____

DENTAL INFORMATION AND HISTORY

How would you rate the condition of your mouth? ___Excellent ___ Good ___ Fair ___ Poor
What is your immediate concern: _____?

Is there anything about the appearance of your teeth that you would like to change? If so, explain:	☐ Yes ☐ No
Have you ever whitened (bleached) your teeth?	☐ Yes ☐ No
Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐ Yes ☐ No
Have you been disappointed with the appearance of your dental work?	☐ Yes ☐ No
Are you happy with your smile?	☐ Yes ☐ No
Do you like the color of your teeth?	☐ Yes ☐ No
Have you ever had:	
Orthodontic treatment?	☐ Yes ☐ No
Oral surgery?	☐ Yes ☐ No
Periodontal treatment?	☐ Yes ☐ No
A mouth plate or mouth guard?	☐ Yes ☐ No
Had a serious injury to mouth or head? If so, explain: _____	☐ Yes ☐ No
Are any of your teeth sensitive to ___ Hot or cold? ___Sweets? ___Biting or chewing?	☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes ☐ No
Do your gums bleed or hurt?	☐ Yes ☐ No
Have you experienced gum disease or tooth loss?	☐ Yes ☐ No
Have you noticed any loose teeth or a change in your bite?	☐ Yes ☐ No
Do you have difficulty in chewing on either side of your mouth?	☐ Yes ☐ No
Do you bite your lips or cheeks regularly?	☐ Yes ☐ No
Does food tend to become caught between your teeth? If yes where? _____	☐ Yes ☐ No
Do you feel nervous about having dental treatments? If yes, what is your biggest concern_____	☐ Yes ☐ No
Have you ever been advised to pre-medicate before having dental treatment?	☐ Yes ☐ No

MEDICAL INFORMATION & HISTORY

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 inter-relationship with the dentistry you will receive. Thank you for answering the following questions:

- ☐ Are you currently pregnant or trying to get pregnant? _____
- ☐ Are you under a physician's care now? If yes explain:_____
  Physician's Name: _____
- ☐ Please list all medications, supplements and/or vitamins that you are presently taking:

_____ _____ _____
_____ _____ _____

Allergies: check all that apply

☐ Aspirin
☐ Acrylic
☐ Sulfa Drugs
☐ Penicillin
☐ Codeine
☐ Latex
☐ Metal

Please list other allergies below:
_____
_____
_____

Have you sustained injury to: check all that apply: ☐ Head? ☐ Neck? ☐ Face? ☐ Teeth? ☐ Other?

Do you drink 4 or more cups of coffee per day?	☐ Yes ☐ No
Have you had prior orthodontic treatments?	☐ Yes ☐ No
Do you have trouble breathing through your nose?	☐ Yes ☐ No
Do you smoke tobacco?	☐ Yes ☐ No
Do you consume alcohol or take sedatives?	☐ Yes ☐ No

Do you have or have you experienced any of the following? Check all that apply:

- ☐ Heart Disorder / Heart Attack?
- ☐ Heart Murmur?
- ☐ Mitral Valve Prolapse?
- ☐ Heart Pacemaker?
- ☐ Heart Palpitations?
- ☐ Heart Valve Replacement?
- ☐ Fluid retention?
- ☐ Frequent ear infections?
- ☐ Frequent sore throats?
- ☐ Sinus problems?
- ☐ Shortness of Breath?
- ☐ Hearing Impairment?
- ☐ Memory Loss?
- ☐ Hay Fever?
- ☐ Poor circulation?
- ☐ Muscle Aches?
- ☐ Muscle Fatigue?
- ☐ Muscle spasms?
- ☐ Muscle tremors?
- ☐ Psychiatric Care?
- ☐ Recent weight gain?
- ☐ Recent weight loss?
- ☐ Slow healing sores?
- ☐ Speech difficulties?
- ☐ Swollen, stiff, painful joints?
- ☐ Tired muscles?
- ☐ Irregular Heartbeat?
- ☐ High blood pressure?
- ☐ Low blood pressure?
- ☐ Stroke?
- ☐ Bleeding easily?
- ☐ Bruising easily?
- ☐ Cancer of _____
- ☐ Chemotherapy Treatments?
- ☐ Radiation Treatments?
- ☐ Anemia?
- ☐ Artificial joints?
- ☐ Asthma?
- ☐ Birth defects?
- ☐ COPD?
- ☐ Diabetes?
- ☐ Epilepsy?
- ☐ Emphysema?
- ☐ Glaucoma?
- ☐ Gastroesophageal reflex (gerd)?
- ☐ Hemophilia?
- ☐ Hepatitis?
- ☐ History of substance abuse?
- ☐ Hypoglycemia?
- ☐ Huntington's disease?
- ☐ Kidney disease?
- ☐ Leukemia?
- ☐ Liver disease?
- ☐ Migraines?
- ☐ Meniere's disease?
- ☐ Multiple sclerosis?
- ☐ HIV/Aids

AUTHORIZATION AND RELEASE I certify that I have read and understand the above questions and that I have answered them accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Additionally, I understand that appropriate credit bureau reports may be obtained.

CONSENT FOR SERVICES Financial responsibility on the part of each patient must also be determined before treatment. Financial arrangements must be made in advance of any treatment being rendered. All dental services performed in this office without previous financial arrangements, must be paid for in full at the time of service. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. Any estimated patient portion is ONLY an estimate and may be different after the actual payment from the insurance company is received. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If your account has to be sent to a collection agency, a $25.00 fee will be charged to your account. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

HIPAA ACKNOWLEDGMENT I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form, I understand that information used or disclosed, pursuant to this authorization could be subject to re-disclosure by the recipient and if so, may not be subject to federal or state law protecting it confidentiality. I understand the above information and agree with its contents.

Please Check Box: ☐ I have read the above conditions of treatment and payment and agree to their content.

Patient's Signature: _____ Date: ___-____-____

Relationship to Patient: _____

I verbally reviewed the medical/dental information above for the parent / guardian & patient named herein.

_____ _____

Staff/ Dr.'s Initials **Date**