ABOUT YOU

Today's Date ______

Name ______

Name you liked to be called ______

Street address ______

City, State, Zip ______

Home phone ______

Work phone ______

Beeper or cell phone ______

Where and when is the best time to reach you? ______

Social Security Number ______

Employer ______

Occupation ______

Referred by ______

Birthdate ______ ☐ Male ☐ Female

In the event of an emergency, is there a relative, friend or neighbor we can contact?

Name ______

Relationship ______

Work ______

Home ______

Person responsible for your bill ______

Billing address, if different

Address ______

City, State, Zip ______

DENTAL INSURANCE

Do you have dental insurance? ☐ Yes ☐ No

Is your insurance through your employer? ☐ Yes ☐ No

Is your insurance through your spouse's employer? ☐ Yes ☐ No

Is your insurance through your parent or guardian ☐ Yes ☐ No

Primary dental insurance company ______

Person with primary dental coverage ______

Social security number of person with primary dental coverage ______

Birthdate of person with primary dental coverage ______

Employer of person with primary dental coverage ______

Group number ______

Insurance company phone ______

Do you have secondary dental insurance? ☐ Yes ☐ No

Secondary dental insurance company ______

Person with secondary dental coverage ______

Social security number of person with secondary dental coverage ______

Birthdate of person with secondary dental coverage ______

Employer of person with secondary dental coverage ______

Group number ______

Insurance phone number ______

MEDICAL HISTORY

Are you currently under the care of any physician? ☐Yes ☐No

If yes, please explain ______

Do you have a medical condition that requires you to take antibiotics prior to dental treatment, such as mitral valve prolapse, heart murmur or joint replacement? ☐Yes ☐No

Did you take your premedication today? ☐Yes ☐No

What did you take and how much? ______

DENTAL HISTORY

Why have you come to the dentist today? ______

Are you currently in pain? ☐Yes ☐No

Have you had any recent dental work on the tooth in question or other teeth? ☐Yes ☐No

If yes, please explain ______

The approximate date of your last dental visit: ______

Have you had TMJ problems (pain or discomfort in your jaw joints)? ☐Yes ☐No

Do you experience stress or anxiety when you visit a dental office? ☐Yes ☐No

Which of the following describes the way you feel about today's visit?

☐ I am not anxious.

☐ I am anxious but not much.

☐ I am anxious and wish I weren't here.

☐ I am so anxious that I would leave if I could.

☐ I am so anxious that I can't even describe how anxious I am.

AGREEMENT & INFORMED CONSENT

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 confidence and it is my responsibility to inform this office of any changes in my medical status.

I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal therapy is indicated. If root canal therapy is indicated, I consent to the necessary treatment.

I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even an extraction.

I also understand that only the root canal treatment will be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

I understand that it is my responsibility to schedule an appointment with my dentist to have the tooth permanently restored. This appointment must be scheduled within six weeks following completion of the Endodontic treatment. If the tooth is not restored within that time frame, I run the risk of coronal leakage or tooth fracture resulting in the need for endodontic retreatment or extraction of the tooth.

I also acknowledge full responsibility for the payment for such service and agree to pay for them, in full, in accordance with the current office policy, unless other specific arrangements are made with the office. I understand that my dental insurance carrier may pay less than the actual bill for services.

I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process dental insurance claims. I have been informed regarding the monetary amount due at this visit. I plan to make the payment today with:

☐Cash ☐Check ☐VISA ☐MC ☐Discover

Signature ______ Date ______

GREGORY S. MYERS, DDS, MS, INC.
PRACTICE LIMITED TO ENDODONTICS

6175 SOM Center Rd. ● Suite 150
Solon, Ohio 44139
Phone: 440-248-3747

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Gregory S. Myers, DDS, MS, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health bills or to conduct health care operation of Gregory S. Myers, DDS, MS, Inc. I understand that diagnosis or treatment of me by Dr. Gregory Myers may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Gregory S. Myers, DDS, MS, Inc. is not required to agree to the restrictions that I may request. However, if Gregory S. Myers, DDS, MS, Inc. agrees to a restriction that I request, the restriction is binding on Dr. Gregory Myers.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Gregory Myers has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Gregory S. Myers, DDS, MS, Inc. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and has disclosures of my protected health information that will occur in my treatment, payment or my bills or in the performance of health care operations of Gregory S. Myers, DDS, MS, Inc. The Notice of Privacy Practices also describes my rights and Gregory S. Myers, DDS, MS, Inc. duties with respect to my protected health information.

Gregory S. Myers, DDS, MS, Inc reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail.

____
Signature of Patient or Representative

____
Name of Patient Date

PATIENT Health History

		Allergies	Medications
☐ Current Med Trt	☐ Ulcers/Digestive	☐ Penicillin	☐ No Medications
☐ Osteoporosis	☐ Migraine/Headaches	☐ Other Antibiotics	☐ Antibiotic
☐ High/Low Blood Press	☐ Epilepsy/Fainting	☐ Aspirin	☐ Pain Medicine
☐ Respiratory/Asthma	☐ Glaucoma/Visual	☐ Tylenol	☐ Heart Medicine
☐ Rheumatic Fever	☐ Mental/Neural	☐ Ibuprofen	☐ Aspirin
☐ Immunocompromised	☐ Tumor/Neoplasms	☐ Codeine	☐ Cortisone/Steriods
☐ Anemia/Bleeding	☐ Alcoholism/Addiction	☐ Narcotics	☐ Blood Thinner
☐ Sickle Cell Disease	☐ HIV+/AIDS	☐ Local Anesthetics	☐ Blood Pressure
☐ Diabetes/Kidney	☐ Venereal Disease	☐ Valium/Tranquil.	☐ Hormone
☐ Psychiatric Care	☐ Herpes/Cold Sores	☐ Latex	☐ Thyroid
☐ Thyroid/Hormonal	☐ Heart Disease	☐ Nitrous Oxide	☐ Birth Control Pills
☐ Hypoglycemia	☐ Mitral Valve Prolaps	☐ Household Bleach	☐ Insulin
☐ Smoke	☐ Heart Murmur/Defect	☐ Sulfa	☐ Ulcer/Nexium
☐ Shortness of Breath	☐ Pacemaker	☐ List others below:	☐ Bone Related
☐ Cancer	☐ Heart Attack/Stroke	☐	☐ Antidepressants
☐ Radiation/Chemo	☐ Irregular Heart Beat	☐ No Epinephrine	☐ Antivirals
☐ Tuberculosis	☐ Prosthetic Implant	☐	☐ Protease Inhibitors
☐ Fatigue	☐ Organ Transplant	☐	☐ Bisphosphonates
☐ Pregnant	☐ Joint Replacement	☐	☐
☐ Hepatitis	☐ Arthritis	☐	☐
☐ Liver Disease	☐ Sinus Problems		

Notes

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Please write down all medications you are taking

The information above is correct

________________________ ____________

Name Date