Today's Date ______________________________

Purpose of Visit ______________________________

Dr., Mr., Mrs., Miss ______________________________ Birthdate ______________
Last First Middle

Email Address ______________________________ Cell Phone ( ) ______________

Residence Address ______________________________
Street Number

______________________________ Home Phone ( ) ______________
City State ZipCode

Social Security Number ______________ Drivers License # ______________

Occupation ______________ Employer ______________ Number of Years ______

Business Address ______________________________ Phone ( ) ______________
Street Number

____
City State ZipCode

Name of Spouse ______________ Spouse's Occupation ______________

Spouse's Employer ______________________________
Name Address

Person Financially Responsible for this Account ______________________________

Address ______________________________ Phone ( ) ______________
Street Number City State ZipCode

Person to Call In Case of Emergency ______________ Phone ( ) ______________

REFERRED BY ______________ **WHEN** ______________

REGISTRATION FORM

ASSIGNMENT OF INSURANCE BENEFITS

CARRIER NAME ____________________ ADDRESS ____________________ PHONE # ____________

Employee / Subscriber Name First Middle Last	Social Security No.	Date of Birth Mo. | Day | Year
Employee / Subscriber Mailing Address	Employer (Company) Name and Address	
City, State, Zip		

Group Number	Location (Local)	Are Other Family Members Employed? Employee Name Soc. Sec. No.	Name and Address of Employer	
Is Patient Covered By Another Dental Plan?	Dental Plan Name	Union Local	Group No.	Name and Address of Carrier

		Self	Spouse	Child	Other
Dependents: ____________	DOB ___/___/___	____	____	____	____
____________	DOB ___/___/___	____	____	____	____
____________	DOB ___/___/___	____	____	____	____
____________	DOB ___/___/___	____	____	____	____
____________	DOB ___/___/___	____	____	____	____

The undersigned, hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____ hereby authorize
Name of Insured

____ to pay and hereby
Name of Company

assign directly to Dr. Carl A. Meyers, all dental benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to Dr. Carl A. Meyers. Authorization is hereby given to release all information necessary to the payment of said benefits. This signature is "IRREVOCABLE", and is valid for two years from this date, unless revoked by me at an earlier date.

____ Date ____________
Authorized Signature of Covered Person/Employee

INSURANCE INFORMATION

Patient's Name______________________________

	Yes	No
Have you had orthodontic treatment?	( )	( )
Do you have unreplaced missing teeth?	( )	( )
Are your gums red, swollen or tender?	( )	( )
Are your permanent teeth loose or separating?	( )	( )
Do your gums bleed when brushing your teeth?	( )	( )
Have you ever been told you have pyorrhea?	( )	( )
Have you ever had professional instructions on dental home care?	( )	( )
Is any part of your mouth sensitive to temperature, or pressure?	( )	( )
If Yes, which part?______________________________		
Does food catch between your teeth?	( )	( )
If Yes, where?______________________________		
Do you have any pain or soreness around the eyes, or ears?	( )	( )
Do you have bad breath?	( )	( )

Occlusal Screening

1. Do you clench or grind your teeth during the day?	( )	( )
2. Have you been made aware of clenching or grinding your teeth during the night?	( )	( )
3. Do you have chronic headaches, or neck and shoulder pains?	( )	( )
4. Do you ever wake up with an awareness of, or about, your teeth or jaw like you've had them clenched in your sleep?	( )	( )
5. Do you have any awareness in the muscles of your neck or shoulders?	( )	( )
6. Do you have a tight or stiff neck?	( )	( )
7. Do you now, or have you ever had, pain in your jaw joint or the sides or your face (in and about the ears)?	( )	( )
8. Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?	( )	( )
9. Which side do you chew on?	L ( )	R ( )
10. Do you know the meaning of traumatic occlusion?	( )	( )

Additional Comments
(For Dr.'s use only)

ANEST.	
N2O	

DENTAL HISTORY

MED.ALERT

Patient's Name____

LAST FIRST INITIAL DATE OF BIRTH

1. Physician's Name______________________________
Address______________________________
2. Are you under a physician's care ?.. YES NO
Since when______________Why______________
3. When was your last complete physical exam ?______________
4. Are you taking any medications?......PLEASE LIST........→.................... YES NO
5. Do you routinely take health related substances ? (ex: aspirin a day).................. YES NO
6. Are you allergic to any medications or substances (penicillin, antibiotics, anesthetics or other medications) ?.. YES NO
7. Do you have any other allergies?.. YES NO
8. Are you sensitive to any metals or latex ?.. YES NO
9. Are you pregnant or suspect you may be ?.. YES NO
10. Do you use any birth control medications ?.. YES NO
11. Have you ever been treated for or been told you might have a heart disease ? ... YES NO
12. Do you have a pacemaker or an artificial heart valve implant ?........................ YES NO
13. Have you ever had rheumatic fever ?.. YES NO
14. Are you aware of any heart murmurs ?.. YES NO
15. Do you have high or low blood pressure ?.. YES NO
16. Have you ever had a serious illness or major surgery ?.. YES NO
If so, explain______________________________
17. Have you ever had radiation treatment or chemo treatment for a tumor growth or other condition?.. YES NO
18. Do you have inflammatory diseases, such as arthritis or rheumatism ?.............. YES NO
19. Do you have any artificial joints/prothesis ?.. YES NO
20. Do you have any blood disorders, such as anemia, leukemia, etc ?.................. YES NO
21. Have you ever bled excessively after being cut or injured ?........................ YES NO
22. Do you have any gastrointestinal problems ?.. YES NO
23. Do you have any kidney problems ?.. YES NO
24. Do you have any liver problems ?.. YES NO
25. Are you diabetic ?.. YES NO
26. Do you have asthma ?.. YES NO
27. Do you have epilepsy or seizure disorders ?.. YES NO
28. Have you tested HIV positive ?.. YES NO
29. Do you have AIDS ?.. YES NO
30. Have you had or do you test positive for hepatitis ?.. YES NO
31. Do you or have you had T.B. ?.. YES NO
32. Do you smoke, chew, use snuff or any other form of tobacco ?...................... YES NO
33. Do you habitually use controlled substances ?.. YES NO
34. Do you habitually use or have been treated for alcohol YES NO
or other substances abuse ?.. YES NO
35. Do you have any disease, condition, or problem not listed ? If so, explain______________
____
36. Is there anything else we should know about your health that we have not covered in this form ?______________
37. Would you like to speak to the Doctor privately about any problem ?.............. YES NO

COMMENTS

____

Initial________ Date ______________

____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE______________________________ DATE______________

DENTIST'S SIGNATURE______________________________ DATE______________

ANEST.

MEDICAL HISTORY

MED. ALERT