Karen P. Meyers, D.D.S.
1875 Southfield Road
Birmingham, MI 48009 • 248-646-2450

Patient Information

Today's Date _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

Preferred phone # to confirm appointments _____

Sex ☐ M ☐ F Age _____

Birthdate _____

Social Security Number _____

☐ Married ☐ Single ☐ Minor

Occupation _____

Employer _____

Address _____

_____

Emergency Contact _____

Home Phone _____

Work Phone _____

Cell Phone _____

Spouse's Work _____

Spouse's Cell _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Relationship to Patient _____

Dental Insurance

Insurance Co. _____

Enrollee ID _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ Social Security # _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign
Name of Insurance Company(s)

directly to Dr. Karen P. Meyers, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Dental History

Reason for today's visit _____

_____

Previous Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" to indicate if you have had any of the following:

Bad breath	☐ Yes	Burning sensation on tongue	☐ Yes	Mouth pain	☐ Yes
Bleeding gums	☐ Yes	Cigarette/pipe/cigar smoking	☐ Yes	Orthodontic treatment	☐ Yes
Blisters on lips/in mouth	☐ Yes	Clicking or popping jaw	☐ Yes	Pain around ear	☐ Yes
Broken fillings	☐ Yes	Dry mouth	☐ Yes	Periodontal treatment	☐ Yes
		Fingernail biting	☐ Yes	Sensitivity to cold	☐ Yes
		Food collection between teeth	☐ Yes	Sensitivity to heat	☐ Yes
		Grinding teeth	☐ Yes	Sensitivity to sweets	☐ Yes
		Growth in mouth	☐ Yes	Sensitivity to biting/chewing	☐ Yes
		Gums swollen or tender	☐ Yes	Sores or growths in your mouth	☐ Yes
		Jaw pain	☐ Yes	Tooth Pain	☐ Yes
		Lip or cheek biting	☐ Yes		
		Loose teeth	☐ Yes	How often do you floss? _____	
		Mouth breathing	☐ Yes		

How often do you brush? _____

Health History

Medical Doctor's Name _____

Address _____ Phone _____

Place a mark on "yes" to indicate if you have had any of the following:

Acid Reflux	☐ Yes	Epilepsy	☐ Yes	Psychiatric Care	☐ Yes
AIDS/HIV	☐ Yes	Fainting or dizziness	☐ Yes	Radiation Treatment	☐ Yes
Anemia	☐ Yes	Glaucoma	☐ Yes	Respiratory Disease	☐ Yes
Arthritis	☐ Yes	Headaches	☐ Yes	Rheumatic Fever	☐ Yes
Artificial Heart Valve	☐ Yes	Heart Attack	☐ Yes	Scarlet Fever	☐ Yes
Artificial Joint	☐ Yes	Heart Problems	☐ Yes	Shortness of Breath	☐ Yes
Asthma	☐ Yes	Heart Valve Replacement	☐ Yes	Sinus Trouble	☐ Yes
Back Problems	☐ Yes	Hepatitis Type_____	☐ Yes	Skin Rash	☐ Yes
Birth Control Pills	☐ Yes	Herpes	☐ Yes	Special Diet	☐ Yes
Bleeding abnormally, with extractions or surgery	☐ Yes	High Blood Pressure	☐ Yes	Stent	☐ Yes
		Insulin Dependent	☐ Yes	Stroke	☐ Yes
Blood Disease	☐ Yes	Jaundice	☐ Yes	Swollen Feet or Ankles	☐ Yes
Cancer	☐ Yes	Jaw Pain	☐ Yes	Swollen Neck Glands	☐ Yes
Chemical Dependency	☐ Yes	Joint Replacement	☐ Yes	Thyroid Problems	☐ Yes
Chemotherapy	☐ Yes	Kidney Disease	☐ Yes	Tonsillitis	☐ Yes
Circulatory Problems	☐ Yes	Liver Disease	☐ Yes	Tuberculosis	☐ Yes
Congenital Heart Lesions	☐ Yes	Low Blood Pressure	☐ Yes	Tumor or growth on head or neck	☐ Yes
Contact Lenses	☐ Yes	Mitral Valve Prolapse	☐ Yes	Tumor or growth in mouth	☐ Yes
Cortisone Treatments	☐ Yes	Nervous Problems	☐ Yes	Ulcer	☐ Yes
Cough, persistent or bloody	☐ Yes	Organ Transplant	☐ Yes	Venereal Disease	☐ Yes
Diabetes	☐ Yes	Pacemaker	☐ Yes	Weight Loss	☐ Yes
Emphysema	☐ Yes	Pregnant? Due Date_____			

Medications

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone _____

List any Medications – Vitamins – Supplements you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

- ☐ Penicillin
- ☐ Erythromycin
- ☐ Clindamycin
- ☐ Azithromycin
- ☐ Clarithromycin
- ☐ Keflex
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Other: _____

_____

_____

Patient Signature

_____

Print Name

Karen P. Meyers, DDS

Welcome to our dental practice. We look forward to serving you for all your dental needs. Our mission is to provide quality comprehensive care in a convenient and comfortable setting. We strive toward creating a patient friendly and family friendly environment. Please feel free to inquire about any service or oral health question at any time. We hope to make your visits with us as pleasant as possible.

FINANCIAL POLICY

1. Payment is due at the time services are rendered. Payment may be made by cash, check, MasterCard or Visa.
2. If you have dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill for reimbursement for your treatment.
3. We will provide your insurance company with all available information to enable you to get the most coverage from your policy.
4. For dental services requiring multiple visits (e.g. crowns, bridges and root canals), 50% of your payment, or copayment, is due at the first visit and 50% at the completion of the procedure.
5. Please notify us at least 24 hours in advance of any appointment change or cancelation. A $50 charge will be applied to your account for any missed appointment or cancellation with less than 24 hours notice.
6. A fee of $3o will be assessed for any returned check.
7. If you require other financial arrangements, please speak with the office manager before treatment begins. We do offer a payment plan through a third party: Care Credit offers interest free payment plans for us up to 6 months.
8. If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collections of your benefits directly from your insurance carrier.

I have read and agree to follow the above financial guidelines.

Signature: _____

Date: _____

KAREN P. MEYERS, DDS * 1875 SOUTHFIELD ROAD * BIRMINGHAM, MI 48009

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/1/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

When required by law: Your consent may also be required in order for this office to make uses and disclosures of your health information if required by Michigan law.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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