welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female

Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. _____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits other-wise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am finan-cially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

Form No. T110R

REGISTRATION

(800) 243-4675

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
   Address: _____ Tel. _____
6. When was the last time your teeth were cleaned? _____

CHECK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ☐YES ☐NO
   How often: _____
8. Were dental x-rays taken? ☐YES ☐NO
9. Have you lost any teeth or have any teeth been removed? ☐YES ☐NO
   Why? _____
10. Have they been replaced? ☐YES ☐NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
    d. Implant _____ Age _____
12. Are you unhappy with the replacement? ☐YES ☐NO
    If yes, explain _____
13. Would you like to know about permanent replacements? ☐YES ☐NO
14. Have you ever had any problems or complications with previous dental treatment? ☐YES ☐NO
    If yes, explain: _____
15. Do you clench or grind your teeth? ☐YES ☐NO
16. Does your jaw click or pop? ☐YES ☐NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ☐YES ☐NO
18. Do you have frequent headaches, neckaches or shoulder aches? ☐YES ☐NO
19. Does food get caught in your teeth? ☐YES ☐NO
20. Are any of your teeth sensitive to: ☐Hot? ☐Cold? ☐Sweets? ☐Pressure?
21. Do your gums bleed or hurt? ☐YES ☐NO
    When? _____
22. Do you experience dry mouth? ☐YES ☐NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ☐YES ☐NO
    How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ☐YES ☐NO
26. Are you unhappy with the appearance of your teeth? ☐YES ☐NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ☐YES ☐NO
29. Have you ever had gum treatment or surgery? ☐YES ☐NO
    What? _____
    Where? _____
    When? _____
30. Have you had any orthodontic work? _____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
32. Do you have any questions or concerns? ☐YES ☐NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

welcome

PATIENT NUMBER

Patient's Name _____
Last First Date of Birth

CHECK THE APPROPIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW' ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
   Address _____
   Tel: _____
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 or substances? ☐YES ☐NO
   If yes, please list medications in comments section or on the back of this form.)
5. Do you take health related substances? (Vitamins, herbal supplements, natural products) ☐YES ☐NO
6. Are you allergic to any medications or substances? (please list) ☐YES ☐NO
7. Do you have any allergies or hives? ☐YES ☐NO
8. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? ☐YES ☐NO
9. Are you sensitive to any metals or latex? ☐YES ☐NO
10. Are you pregnant or suspect you may be? ☐YES ☐NO
11. Do you use any birth control medications? ☐YES ☐NO
12. Have you ever been treated for or been told you might have heart disease? ☐YES ☐NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ☐YES ☐NO
14. Have you ever had rheumatic fever? ☐YES ☐NO
15. Are you aware of any heart murmurs? ☐YES ☐NO
16. Do you have high or low blood pressure? (state high or low) ☐YES ☐NO
17. Have you ever had a serious illness or major surgery? ☐YES ☐NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ☐YES ☐NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ☐YES ☐NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ☐YES ☐NO
21. Do you have any artificial joints/prosthesis? ☐YES ☐NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ☐YES ☐NO
23. Have you ever bled excessively after being cut or injured? ☐YES ☐NO
24. Do you have any stomach problems? ☐YES ☐NO
25. Do you have any kidney problems? ☐YES ☐NO
26. Do you have any liver problems? ☐YES ☐NO
27. Are you diabetic? ☐YES ☐NO
28. Do you have fainting or dizzy spells? ☐YES ☐NO
29. Do you have asthma? ☐YES ☐NO
30. Do you have epilepsy or seizure disorders? ☐YES ☐NO
31. Do you or have you had venereal or any sexually transmitted disease? ☐YES ☐NO
32. Have you tested HIV positive? ☐YES ☐NO
33. Do you have AIDS? ☐YES ☐NO
34. Have you had or do you test positive for hepatitis? ☐YES ☐NO
35. Do you or have you had T.B.? ☐YES ☐NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? ☐YES ☐NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ☐YES ☐NO
38. Do you habitually use controlled substances? ☐YES ☐NO
39. Have you had psychiatric treatment? ☐YES ☐NO
40. Have you taken any prescription drugs fnefluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ☐YES ☐NO
41. Do you have any disease condition, or problem not listed? If so, explain _____ ☐YES ☐NO
42. Is there anything else we should know about your health that we have not covered in this form? _____ ☐YES ☐NO
43. Would you like to speak to the Doctor privately about any problem? ☐YES ☐NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

ANEST.

Form No. T140MH

MEDICAL HISTORY

MED. ALERT

Metzger Dentistry
1213 Hall Johnson Road, Suite 100
Colleyville, TX 76034
(817) 428-1800

ACKNOWLEDGEMENT OF RESPONSIBILITY

I have read, verified and completed the Patient Registration forms, dated _____, and I can attest to their accuracy to the best of my knowledge.

I understand it is my responsibility to inform your office of any information changes, insurance changes, or phone/address changes at the time I sign in for each appointment. Any information withheld could affect my insurance coverage and make me responsible for payment at the time of service.

I understand that I am legally responsible for **all charges** incurred for my care.

Payment is expected when services are rendered, unless alternative arrangements have been made in advance.

As a courtesy to me, the office of **Metzger Dentistry**, will attempt to gather as much information as possible regarding my insurance. It is my full responsibility to be aware of all coverage and benefits on my policy.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to **Metzger Dentistry**. I understand that I am financially responsible for any balance not covered by my insurance company.

I understand that any remaining balance which is over 30 days past due will be paid upon receipt of statement. I understand that any unpaid account is considered delinquent after 30 days and is subject to collection action, through a service reporting to credit bureaus.

I understand that there will be a charge of $20.00 for any returned checks.

I understand that if I am unable to keep my appointment, I must notify the office at least 24 hours before my scheduled appointment time.

Patient Name _____

Signature _____

Patient or legally responsible party

Date _____

Metzger Dentistry
1213 Hall Johnson Road, Suite 100
Colleyville, TX 76034
(817) 428-1800

INSURANCE AUTHORIZATION

We realize that dental insurance is complex, and it can be difficult to understand the treatments covered by some dental insurance companies. As a courtesy to you, our office is happy to help you process your insurance. We will do everything possible to help you understand and make the most of your dental insurance benefits.

Insurance coverage is usually limited to a portion of the fee agreed to by you and our office. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company. Unfortunately, some of the services that you may need will not be covered by your dental insurer. Our goal is to help you achieve and maintain optimal dental care, which is not necessarily the goal of the dental insurance companies.

Our office will complete and submit dental insurance forms to the insurance company to achieve the maximum reimbursement to which you are entitled. We will work diligently to complete the process as quickly as possible.

Please let us know if you have any questions about your dental insurance coverage. It will be our pleasure to help you.

_____ I authorize payment of dental benefits directly to Metzger Dentistry.

_____ I authorize the release of all necessary information to the insurance provider and their representatives.

_____ I have read this form and agree to be financially responsible for items not covered by the insurance provider.

Patient Name _____

Signature _____
Patient or legally responsible party

Date _____