

## Dr. Austin B. Meares

### Permission for Diagnostic and Treatment Procedures

I authorize Dr. Meares, his agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at the office of Dr. Meares. If I require specialized and or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Dr. Meares.

### Consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

I further understand that as part of my healthcare, the office of Dr. Meares originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Meares reserves the right to change his notice and practices and prior to implementation will mail or post a copy of any revised notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Meares is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Meares has already taken action in reliance thereon.

I fully understand and accept the terms of this consent.

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Signature of patient (or parent/guardian)

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Date

## Important Information for Our Patients

### Terms of Payment

The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs; therefore, we offer different options to our patients, which allows for payment to be convenient and flexible. We are available to answer any questions you may have.

### Dental Insurance

We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please bring in your insurance explanation of benefits booklet and/or your insurance card to your first visit. Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

We do not accept assignment of benefits for secondary insurance. However, we will provide any needed information allowing you to file and be reimbursed by your secondary carrier.

### PPO Insurance Plans

- We are an “in-network” provider for the following Insurance companies
- Delta Premier
- Cigna

We are a covered provider for most insurance plans as “out of network”

### Payment Options

- We accept Visa, MasterCard, money order, cash or personal check (there will be a fee of \$35.00 charged for all returned checks). We do not accept pre-paid Visa/MasterCard.
- A convenient interest free payment plan through Care Credit
- A pre-authorized monthly payment plan, up to 3 months, on your credit card

### Appointments

In order to allow the best possible care for our patients we reserve specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your reserved time. If you need to change your appointment a 48-hour notice is expected, otherwise a broken appointment fee may be charged to your account.

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### Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company. Therefore, I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Austin Meares.
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

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SIGNATURE OF RESPONSIBLE PARTY

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DATE

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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 interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal     Latex     Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# DR. AUSTIN B. MEARES, D.M.D., P.A.

## REGISTRATION FORM

Today's date:

### PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:	Drivers License #.: ( - - )	Home phone #: ( - - )	
Street address:					Cell phone #: ( - - )	
P.O. Box:		City:		State:	ZIP Code:	
Occupation:		Employer:			Employer phone #: ( - - )	
Email address:			Responsible party:			
Who referred you or how did you hear about our office, so we may thank them?						
Other family members seen here:				Pref. Pharmacy name and #:		

### PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy holder (if other than the patient):	Birth date: / /	Address (if different):			Home phone #: ( - - )
Policy holder's SS#:		Is the policy holder a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Policy holder's Occupation:	Employer:	Employer address:			Employer phone #: ( - - )
Patients relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> other					
Name of primary insurance:				Insurance phone #:	
Street address		P.O. Box:	City:	State:	ZIP Code:
Birth date: / /	Group #:		Policy #:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

### SECONDARY INSURANCE INFORMATION

Policy holder (if other than the patient):	Birth date: / /	Address (if different):			Home phone #: ( - - )
Policy holder's SS#:		Is the policy holder a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Policy holder's Occupation:	Employer:	Employer address:			Employer phone #: ( - - )
Patients relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> other					
Name of secondary insurance:				Insurance phone #:	
Street address		P.O. Box:	City:	State:	ZIP Code:
Birth date: / /	Group #:		Policy #:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

### IN CASE OF EMERGENCY

Name :	Relationship to patient:	Home/cell phone #.:	Work phone #.:
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Austin B. Meares, D.M.D., P.A. or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date