Welcome

Patient Information

Name____ Patients Soc. Sec. #____________________

Last First Initial Preferred Name

Spouse Name____

Address____

City____________________ State__________ Zip__________ Home Phone____________________

Sex ☐ M ☐ F Age________ Birthdate______________ ☐ Single ☐ Married ☐ Child Cell Phone____________________

Email Address____

Patient Employed by________________________________ Occupation____________________

Business Address________________________________ Business Phone____________________

How did you hear about our office?____

Notify in case of emergency____________________ Home Phone______________ Work/Cell______________

Primary Insurance

Insurance Subscriber____

Last Name First Name Middle Initial

Relationship to Patient____________________ Birthdate______________ Soc. Sec. #______________

Address (if different from patient)________________________________ Home Phone____________________

City____________________ State______________ Zip____________________

Subscriber Employed by________________________________ Occupation____________________

Business Address________________________________ Business Phone____________________

Dental Insurance Company________________________________ Insurance Phone____________________

Group #____________________ Subscriber ID #____________________

Name of other dependents under this plan____

Dental History

Former Dentist____________________ Address____________________ Phone______________

Date of last dental care____________________ Date of last x-rays____________________

Mark with an (**X**) if you have had problems with any of the following:

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal Treatment	☐ Sensitivity to sweets
☐ Bleeding Gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth

How often do you brush?________________________________ Floss?____________________

Have you ever experienced an adverse reaction in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment____

What would you like to change about your smile?____

(OVER)

Medical History

Physician's Name_______________________________ Phone_______________

Date of last visit_________________ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe_________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_________________

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Mark with an (**X**) if you have had any of the following:

☐ AIDS/HIV positive
☐ Anaphylaxis
☐ Anemia
☐ Artificial heart valves
☐ Artificial joints
☐ Arthritis, Rheumatism
☐ Asthma
☐ Atopic (allergy prone)
☐ Bizphosphonate therapy
☐ Blood disease
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatments

☐ Cough up blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Food Allergies
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
Describe___________________
____
☐ Hemophilia/abnormal bleeding
☐ Hepatitis (type__________)
☐ Herpes
☐ High blood pressure

☐ Jaw pain
☐ Kidney disease/malfunction
☐ Latex Allergy
☐ Liver disease
☐ Material allergies: (wood, metal, chemicals)
☐ Mitral valve prolapse
☐ Nervous problems
☐ Osteoporosis
☐ Pacemaker or heart surgery
☐ Persistent cough
☐ Psychiatric care
☐ Radiation treatment
☐ Rapid weight loss/gain
☐ Respiratory disease

☐ Rheumatic fever
☐ Shingles
☐ Shortness of breath
☐ Skin rash
☐ Stroke
☐ Surgical implant
☐ Swelling of feet or ankles
☐ Thyroid disease or malfunction
☐ Tobacco habit
☐ Tuberculosis
☐ Ulcer/Colitis
☐ Venereal disease

List any medication you are currently taking, if any:

☐ Aspirin Daily ☐ Bizphosphonates ☐ Coumadin________

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List any drug allergies, if any:

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Authorization

I have reviewed the information on this questionnaire, and attest that it is accurate to the best of my knowledge. I understand that Dr. Miller will use this information to help determine appropriate and healthful dental treatment. If there is any change in my medical status or medications, I understand that I am responsible for informing Dr. Miller.

I hereby authorize Dr. Miller to take any necessary radiographs, photographs, or any other diagnostic aids deemed appropriate to enable him to thoroughly diagnose my/my dependent's treatment needs. I authorize Dr. Miller to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my/my dependent's treatment. I authorize Dr. Miller to choose and employ such assistance as he deems fit. I understand the use of anesthetic agents embodies a certain risk.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I realize that it is a courtesy that Dr. Miller's office files my insurance for me and that they are in no way affiliated with my insurance company and cannot possibly know the benefits and limitations of every policy. **I understand that I am ultimately responsible for payment of services provided in this office for myself and my dependents, regardless of insurance benefits, and that payment is due at the times services are rendered.** The responsibility for any difference between actual charges and what the insurance company pays rests with the patient. I understand there is a $30 fee for any returned checks. I understand that missed appointments and those cancelled with less that 24 hours notice may incur a broken appointment fee of 20% of the total fees scheduled for the allotted time, with a $50 minimum fee. I understand that a finance charge of 2% monthly will be added to any balance over 60 days, with or without insurance coverage, unless other arrangements have been made with the office manager. Any accounts turned over to collections will incur a collection fee of 40% of the balance due. In the event that I default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Please note that the parent bringing in a child (under age 18) for treatment is the parent legally responsible for all fees incurred for the child's treatment, regardless of which parent is the insured.

Signature_______________________________ Date___________________

Payment is due in full at the time services are rendered.