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We warmly welcome you to our office. Please take a few moments to complete the following information so we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: _____

Single Married Divorced

I prefer to be called: _____ Male Female

Birth Date: ____/____/____ S.S.#: ____-____-____

Home Address: _____

Hm#: (____)____-____ Cell#: (____)____-____

Wk#: (____)____-____ Pgr#: (____)____-____

Email: _____

Employer: _____

Employer's Address: _____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous / Present Dentist: _____

Last Visit Date: ____/____/____ Ph#: (____)____-____

Who is responsible for this account?

Name: _____

Relationship: _____

Home Address: _____

Hm#: (____)____-____ Cell#: (____)____-____

Wk#: (____)____-____ Pgr#: (____)____-____

Email: _____

Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____/____/____

Insured's S.S. #: ____-____-____

Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birth Date: ____/____/____

Insured's S.S. #: ____-____-____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relationship: _____

Wk#: (____)____-____ Pgr#: (____)____-____

A note for patients with dental insurance

We will assist you in any way possible to maximize your insurance benefits. We are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to make as close of a calculation as possible of what your insurance plan will cover, however regardless of what your insurance plan pays for you are responsible for all fees.

Medical History

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Are you taking any prescription/over-the-counter drugs? Yes No

Please list: _____

Do you smoke or use tobacco in any other form? Yes No

Have you or do you take Redux/Fen Phen, Pondimin or Fosamax?

Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|-----------------------------|------------------------------|
| Y N Abnormal Bleeding | Y N Herpes/Fever Blisters |
| Y N Alcohol/Drug abuse | Y N High Blood Pressure |
| Y N Anemia | Y N HIV+/AIDS |
| Y N Arthritis | Y N Hospitalized Any Reason |
| Y N Artificial Bones/Joints | Y N Kidney Problems |
| Y N Asthma | Y N Latex allergy |
| Y N Bacterial Endocarditis | Y N Liver Disease |
| Y N Blood Transfusions | Y N Low Blood Pressure |
| Y N Cancer/Chemotherapy | Y N Mitral Valve Prolapse |
| Y N Colitis | Y N Nervous/Anxious |
| Y N Congenital Heart Defect | Y N Pacemaker |
| Y N Diabetes | Y N Prosthetic Cardiac Valve |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Emphysema | Y N Radiation Treatment |
| Y N Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Fainting Spells | Y N Seizures |
| Y N Frequent headaches | Y N Shingles |
| Y N Glaucoma | Y N Sickle cell Disease |
| Y N Hay Fever | Y N Sinus Problems |
| Y N Heart attack | Y N Stroke |
| Y N Heart Murmur | Y N Thyroid Problems |
| Y N Heart Surgery | Y N Tuberculosis |
| Y N Heart Transplant | Y N Ulcers |
| Y N Hemophilia | Y N Venereal Disease |
| Y N Hepatitis | |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following:

- | | | |
|------------------------|------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Tetracycline |
| Y N Codeine | Y N Latex | Y N Sulfa |
| Y N Dental Anesthetics | Y N Penicillin | Y N Ibuprofen |

Please list any other drug you are allergic to: _____

Dental History

Why have you come to the dentist today? _____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? Yes No

If yes, please explain: _____

How would you describe the condition of your teeth and gums?

Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums?

Yes No If yes, please explain: _____

Do you want fresher breath? Yes No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

Do you grind or clench your teeth? Yes No

Please list any other dental conditions that you had that are not mentioned above:

Have you had any problems with any previous dental treatment? Yes No

If yes, please explain: _____

Are you happy with the appearance of your teeth? Yes No

Are you interested in straightening your teeth? Yes No

Are you interested in whitening your teeth? Yes No

If you could change your teeth or smile, what would you change?

What are your hobbies or special interests? (sports, self improvement, education, etc.) _____

Dr. Michael J. Miller

Date _____

I understand that the information is correct to the best of my knowledge.

I understand it will be held in the strictest of confidence and it's my responsibility to inform this office of any changes in my medical status. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or his staff to use any photos taken for lecturing, publishing or education purposes.

Signature _____ Date _____

Patient portion is due in full at time of treatment