PRECISION EXCELLENCE QUALITY
MJM

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

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 Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Sulfa
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: _____

Have you ever had an upsetting dental experience that we should know about? _____

What is your greatest concern about dental treatment (cost, time, pain)

_____

Is there anything else about having dental treatment that you would like us to know? _____

So that we may better serve your dental needs, were there any concerns that you felt your previous dentist did not address? _____

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