|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** | Last | First | Middle I | Male: | Female: |
| Address: | City:  | State: | Zip Code: |
| Home Phone: | Cell Phone: | Work Phone: |
| Date of Birth: | Email Address: | Preferred Contact: Home( ) Cell( ) Work( ) Text Message( ) Email( ) |

**ACCOUNT INFORMATION**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Person responsible for account**Name:

|  |  |  |  |
| --- | --- | --- | --- |
| Last | First | Middle I |  Phone Contact Number: |
| Address: | City: | State: | Zip Code: |

 |
| **Primary Dental Insurance** Insured’s Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last | First | Middle I | SS #: | Date of Birth: |

|  |  |
| --- | --- |
| Employer Name: | Employer Phone #: |
| Address: | City: | State: | Zip Code: |
| Insurance Company Name: |
| Address: | City: | State: | Zip Code: |
| Relationship to Patient: | Subscriber #: | Group # |

 |
| **Secondary Dental Insurance** Insured’s Name:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last | First | Middle I | SS #: | Date of Birth: |

|  |  |
| --- | --- |
| Employer Name: | Employer Phone # |
| Address: | City: | State: | Zip Code: |
| Insurance Company Name: |
| Address: | City: | State: | Zip Code: |
| Relationship to Patient: | Subscriber #: | Group # |

 |

**DENTAL INFORMATION**

|  |
| --- |
| What is the reason for your dental visit today? |
| Are you currently experiencing dental pain or discomfort?  | YES | NO | How long? |
| Last Dental Exam Date: | Last Dental X-rays: |
| **Please check appropriate Box (s)** | **YES** | **NO** |  | **YES** | **NO** |
| Do you smoke or use smokeless tobacco? |  |  | Do you experience headaches? |  |  |
| Are your teeth sensitive to cold, hot, sweets or pressure? |  |  | Do you have difficulty opening, closing or chewing? |  |  |
| Have you ever been treated for periodontal (gum) disease? |  |  | Do you have pain in your joint, ear or side of face? |  |  |
| Do your gums bleed? |  |  | Do you have clicking of jaw, or grind or clench teeth? |  |  |
| Do you have any sores or lumps in your mouth? |  |  | Do you wear any dentures or partial dentures? |  |  |

**MEDICAL PHYSICIAN INFORMATION**

|  |
| --- |
| Name of Medical Physician: |
| Physician’s Telephone Number: | Last Medical Exam Date: |
| I am currently being treated for: |

**Consent to Proceed**

I authorize Dr.Amanda L. Miller, D.D.S. and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any anesthetic, analgesic(including nitrous oxide), therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

 I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but is not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness.

 I understand that placement of fillings may render the involved teeth sensitive to hot and cold temperatures and/or pressure for an extended period of time.

 I acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination.

 I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

 I reserve the right to have alternative methods of care explained to me, if any, as well as the advantages and disadvantages of each.

 I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

**AUTHORIZATION AND RELEASE INFORMATION**

I certify that the above information is correct to the best of my knowledge. I authorize and request my Insurance Co. to pay directly to the Dentist for all submitted claims. I also understand that I may be asked to pay a portion in advance until my Insurance Co. pays, at which time I will be issued a refund for any overpayments. I also understand that on all major services such as crowns, bridges, dentures& partial dentures, etc. that I will be expected to pay ½ in advance and any balance after the Insurance Company pays or at the time of delivery. I also understand that if I receive a statement, full payment is expected within 30 days, unless I have made special payment arrangements with the front office.

Signature of Patient/ Parent or guardian if patient is a minor:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

|  |
| --- |
| **Do you have or have you had any of the following? Please check appropriate Box (s)** |
|  | **YES** | **NO** | **DATE** |  | **YES** | **NO** |
| Heart Surgery, if yes when? |  |  |  | Congenital heart defect |  |  |
| Heart Stents, if yes when? |  |  |  | Previous Endocarditis |  |  |
| Heart Attack, if yes when? |  |  |  | Heart Valve replacement |  |  |
| Pacemaker or Defibrillator, if yes when? |  |  |  | Tuberculosis |  |  |
| Asthma |  |  |
| Joint Replacement, if yes when? |  |  |  | Fainting spells |  |  |
| Cancer, Type: |  |  |  | Anemia |  |  |
| Chemotherapy, if yes when? |  |  |  | Stomach disease/ulcer |  |  |
| Radiation, if yes when? |  |  |  | Bleeding disorders |  |  |
| Stroke, if so when? |  |  |  | Hepatitis/Liver disease |  |  |
| Are you pregnant? Due date: |  |  |  | Epilepsy |  |  |
| Diabetes |  |  |  | Glaucoma |  |  |
| High Blood Pressure |  |  | AIDS/HIV Positive |  |  |
| Autoimmune disease or Rheumatoid arthritis |  |  | Venereal disease |  |  |
| If yes to RA or autoimmune disease, are you under current treatment? |  | Kidney Disease |  |  |
| If yes to above, are you receiving dialysis? |  |  |
| Please LIST any surgeries within the last 2 years: |
|  |
| Please LIST any hospital visits within the last year: Why were you there? |
|  |

|  |  |  |
| --- | --- | --- |
| **Have you taken or are you currently taking any of the following medications?** | **YES** | **NO** |
| Medications for Osteoporosis such as Boniva, Fosamx, Actonel, etc. or treatment for cancer with intravenous Bisphosphonate drugs |  |  |
| Weight reduction drugs such as Fen-Phen or Redux |  |  |
| **Please circle ANY of the following drugs you are ALLERGIC to:**Amoxicillin Penicillin Latex Keflex Biaxin Codeine Aspirin Local AnestheticOther allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you traveled outside the United States in the last 30 days? If so where? |

|  |
| --- |
| Please **LIST ALL** current Medications, include over the counter and herbal supplements. |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Health Questionnaire Acknowledgment**

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date