MILLER CENTER
FOR COMPREHENSIVE DENTISTRY

Patient Information

Title (please circle) Dr. Mr. Mrs. Ms. Name____

Address____City____________________State_______Zip____________

Birthdate__________________Home Phone______________________ Work Phone___________________________

E-mail address____Cell Phone ___________________________

Employer____

Check (x) Appropriate Box: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If a Student, Name of School/College______________________________City_____________________State_________

Whom may we thank for referring you to our practice? ____

Person to Contact in an Emergency____Phone_____________________

Dental Insurance

Name of Insured____ Relationship to Patient_____________________

Birthdate____________Social Security Number ____________________Employer_____________________________

Insurance Company____Group #__________________

Additional Dental Insurance

Name of Insured____ Relationship to Patient__________________

Birthdate____________Social Security Number ____________________Employer_____________________________

Insurance Company____Group #___________________

Authorization

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that Stephen M. Miller, DMD and David B. Fall, D.M.D. are out of network providers with dental insurance companies. I am financially responsible for all charges whether or not paid by insurance.

Signature____Date______________________________

DENTAL HISTORY

Reason for today's visit____

Former Dentist____

Date of last dental visit______________________________________Date of last dental x-rays__________________

Check (x) if you had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gum Disease
- ☐ Loose teeth or broken fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths

How often do you floss?_________________________________How often do you brush?______________________

MEDICAL HISTORY

Physician's (PCP) Name____Date of last visit_____________

Physician's Address____Phone Number______________

Have you ever had any serious illness or operations? ☐ 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 pills? ☐ Yes ☐ No

Check (x) if you had any of the following:

- ☐ AIDS
- ☐ Alcohol Dependency
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disorder
- ☐ Cancer **(Describe Below)** _______________
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ **Heart Problems (Describe Below)** _____________________
- ☐ Hepatitis - Type_____
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recreational Drug Use
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ STD (sexual disease)
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

Additional Comments: ____

MEDICATIONS

List current medications (**INCLUDE Aspirin, Vitamins & Herbal Supplements**)

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ALLERGIES

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ **LATEX**
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____________________

Please list any other conditions we should know about:____

SIGNATURE

To the best of my knowledge the above information is correct and true.

Patient's Signature____Date______________________________