Welcome to our Office!

We are a health-centered dental practice thus we are concerned with your total well-being, not just your oral health. This information is requested in order that we may thoroughly diagnose and treat your condition. All information will be held in strict confidence. THANK YOU!

Miller & Miller, DDS

"Just one look is worth 1,000 words."

P: 972.985.3300 • www.millerandmillerdds.com

Name ______________________________ **Marital Status** S M D W

Home Address ____________ **City** ____________ **Zip** ________ **Res. Tel. (** ____ **)** ____________

Birth Date ____________ **Soc. Sec #** ____________ **Bus. Tel. (** ____ **)** ____________

Employer ______________________________ **Cell Tel. (** ____ **)** ____________

Occupation ____________ **Name of Spouse** ____________ **E-Mail** ____________

Whom may we thank for referring you? ____________ **E-Mail** ____________

MEDICAL HISTORY

HAVE YOU EVER HAD (Please circle Yes or No)

Heart Disease or Heart Attack ... Yes No	AIDS ... Yes No	**ARE YOU ALLERGIC TO:**
Heart Murmur ... Yes No	HIV Positive ... Yes No	Aspirin ... Yes No
Rheumatic Fever ... Yes No	Cancer ... Yes No	Antibiotics e.g.: Penicillin ... Yes No
Mitral Valve Prolapse ... Yes No	Chemotherapy ... Yes No	Codeine ... Yes No
Artificial Heart Valve ... Yes No	Radiation Therapy ... Yes No	Dental Anesthetic (Novocain) ... Yes No
Abnormal Blood Pressure ... Yes No	Thyroid Problems ... Yes No	Other ... Yes No
Heart Pacemaker ... Yes No	Tuberculosis ... Yes No	Are You In Good Health Now? ... Yes No
Artificial Joint (hip, knee, etc.) .. Yes No	Asthma ... Yes No	
Hepatitis ... Yes No	Anemia ... Yes No	**FOR WOMEN ONLY:**
Hemophilia ... Yes No	Sinus Problems ... Yes No	Are You Pregnant? ... Yes No
Diabetes ... Yes No	Epilepsy or Seizures ... Yes No	Birth Control Pills ... Yes No
Arthritis ... Yes No	Do You Use Tobacco? ... Yes No	Hormone Therapy ... Yes No

LIST ANY DRUGS YOU ARE CURRENTLY TAKING AND FOR WHAT REASONS: ______________________________

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT: ______________________________

Physician ____________ Telephone ____________ Date of last complete physical ____________

DENTAL HISTORY

HAVE YOU: (Please circle Yes or No)	**DO YOU:**
Ever been told you have gum trouble ... Yes No	Ever clench your teeth ... Yes No
Ever been treated for periodontal disease ... Yes No	Ever have bleeding gums ... Yes No
Ever had orthodontic treatment ... Yes No	Ever have gum abscesses ... Yes No
Had shifting of teeth ... Yes No	Have unpleasant tastes in your mouth ... Yes No
Had plaque control instructions in your mouth ... Yes No	Ever have bad breath ... Yes No
Ever had cold sores/fever blisters ... Yes No	Have pain or clicking in jaw joint (TMJ) ... Yes No

Do you have tooth sensitivity to: (please circle) ... Heat ... Cold ... Sweet ... Biting Pressure

Are you happy with the appearance of your teeth and/or smile ... Yes No

Do you want to keep your teeth for the rest of your life ... __ Yes, no matter how much trouble __ Don't Know

__ Yes, if it's not too much trouble __ Don't Care

I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner.

Patient's Signature ____________ Date ________ Dentist's Signature ____________

RESPONSIBLE PARTY

Name ______________________ **Birth Date** __________

Address ______________________

Home Phone __________ **Driver's License #** __________ **Sex: M F**

Work Phone __________ **Social Security #** __________

Preferred Method of Payment: CASH CHECK CREDIT CARD

Please list additional family members' names and birth dates:

Name __________ Birth Date ______ Name __________ Birth Date ______

Name __________ Birth Date ______ Name __________ Birth Date ______

Name __________ Birth Date ______ Name __________ Birth Date ______

Nearest friend or relative NOT living in same household

Name ______________________ Phone __________

CONSENT

I have answered all questions honestly and to the best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication. I authorize the doctor or his staff to take any necessary x-rays, models, photos, and other diagnostic aides needed to make a thorough diagnosis of the patient's dental needs. I authorize the doctor and staff to perform and administer treatment, medications, and therapy that may be indicated.

AGREEMENT TO PAY

Payment for dental services provided in this office for myself and my dependents are due and payable at the time services are rendered unless financial arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a billing charge may be added to my account. If an account must be turned over to a collection agency the fee charged by that agency will be added to my account.

Signature ______________________ Date __________
(Patient, Parent, Guardian)

Medical Update:

Date: __________ Date: __________

Date: __________ Date: __________

Date: __________ Date: __________

Date: __________ Date: __________

Notes: ______________________