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 D.D.S., L.L.P.

A Practice in Quality Restorative Dentistry

(972) 985-3300

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
Heart Murmur .... Yes No
Rheumatic Fever .... Yes No
Mitral Valve Prolapse .... Yes No
Artificial Heart Valve .... Yes No
Abnormal Blood Pressure .... Yes No
Heart Pacemaker .... Yes No
Artificial Joint (hip, knee, etc.).. Yes No
Hepatitis .... Yes No
Hemophilia .... Yes No
Diabetes .... Yes No
Arthritis .... Yes No

AIDS .... Yes No
HIV Positive .... Yes No
Cancer .... Yes No
Chemotherapy .... Yes No
Radiation Therapy....... Yes No
Thyroid Problems .... Yes No
Tuberculosis .... Yes No
Asthma .... Yes No
Anemia .... Yes No
Sinus Problems .... Yes No
Epilepsy or Seizures.... Yes No
Do You Use Tobacco? Yes No

ARE YOU ALLERGIC TO:

Aspirin .... Yes No
Antibiotics e.g.: Penicillin .... Yes No
Codeine .... Yes No
Dental Anesthetic (Novocain) .. Yes No
Other .... Yes No

Are You In Good Health Now? Yes No

FOR WOMEN ONLY:
Are You Pregnant? .... Yes No
Birth Control Pills .... 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)

Ever been told you have gum trouble .... Yes No
Ever been treated for periodontal disease .... Yes No
Ever had orthodontic treatment .... Yes No
Had shifting of teeth .... Yes No
Had plaque control instructions in your mouth .... Yes No
Ever had cold sores/fever blisters .... Yes No

DO YOU:

Ever clench your teeth .... Yes No
Ever have bleeding gums .... Yes No
Ever have gum abscesses .... Yes No
Have unpleasant tastes in your mouth .... Yes No
Ever have bad breath .... 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 Signature Date Dentist's Signature

RESPONSIBLE PARTY:

NAME		BIRTH DATE
ADDRESS		
HOME PHONE	DRIVER'S LICENSE #	Sex M F
WORK	SOCIAL SEC. #	

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 of 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 patients 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: