MILLER STUDIO
FOR DENTAL ARTISTRY

PATIENT INFORMATION **DATE** _____

NAME _____ ☐MARRIED ☐SINGLE ☐CHILD ☐ MALE ☐FEMALE

SOCIAL SECURITY / PATIENT ID _____ BIRTHDATE _____

ADDRESS _____CITY_____STATE_____ZIP_____

PHONES: HOME _____ WORK _____ CELL _____

E-MAIL _____ PREFERRED METHOD OF CONTACT_____

PATIENT EMPLOYER _____ F/T STUDENT?_____ SCHOOL _____

EMPLOYER ADDRESS _____CITY____-----_____STATE_____ZIP_____

How did you hear about us? _____

Emergency Contact _____Phone _____

RESPONSIBLE PARTY

Person responsible for this account _____ Relationship _____

Address (if different from above) _____

Phone _____ Work Phone _____Cell _____

Name and address of employer _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security/Subscriber ID _____

Employer _____ Address _____

Work phone _____

Insurance Company _____ Group # _____

Insurance Co Address _____ City_____ State_____ ZIP_____

How much is your deductible? _____ Annual Maximum _____ Remaining amount _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security/Subscriber ID _____

Employer _____ Address _____

Work phone _____

Insurance Company _____ Group # _____

Insurance Co Address _____ City_____ State_____ ZIP_____

How much is your deductible? _____ Annual Maximum _____ Remaining amount _____

METHOD OF PAYMENT

- ☐ Responsible party currently has an account with this office
- ☐ Payment in full at each appointment (cash, check or credit card)
- ☐ I wish to discuss the Dental Office's Financial Policy

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

DENTAL HISTORY

What is the nature of today's visit? ☐ Exam ☐ Consultation ☐ Emergency _____

Former Dentist _____ Phone _____ City _____

Date of last dental care _____ Date of last x-rays _____

Please check any of the following that apply to you:

☐ Bad breath	☐ Bleeding gums	☐ Clicking / popping of the jaw	☐ Trapping food between teeth
☐ Grinding teeth	☐ Loose teeth or broken fillings	☐ Periodontal treatment	☐ Sensitivity to cold
☐ Sensitivity to sweets	☐ Sensitivity when biting	☐ Sores or growths in mouth	☐ Sensitivity to hot

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? _____

Other information about your dental health or previous treatment? _____

MEDICAL HISTORY

Physician's Name _____ City _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date _____

Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No Have you ever taken osteoporosis medications? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Using birth control medication? ☐ Yes ☐ No

Check ☑ if you have had any of the following:

☐ AIDS/HIV positive	☐ Cough, persistent	☐ High blood pressure	☐ Rheumatic/scarlet fever
☐ Anaphylaxis	☐ Cough up blood	☐ Jaw pain	☐ Shingles
☐ Anemia	☐ Diabetes	☐ Kidney problem	☐ Shortness of breath
☐ Arthritis, rheumatism	☐ Epilepsy	☐ Liver disease	☐ Skin rash
☐ Artificial heart valve	☐ Fainting	☐ Material allergies	☐ Spina Bifida
☐ Artificial joints	☐ Food allergies	(latex, wool,	☐ Surgical Implant
☐ Asthma	☐ Glaucoma	metal, chemicals)	☐ Swelling of feet
☐ Atopic (allergy prone)	☐ Headaches	☐ Mitral valve prolapse	or ankles
☐ Back problem	☐ Heart murmur	☐ Nervous problems	☐ Thyroid disease/
☐ Blood disease	☐ Heart problems	☐ Pacemaker/	malfunction
☐ Cancer	describe _____	heart surgery	☐ Tobacco habit
☐ Chemical dependency	☐ Hemophilia/abnormal	☐ Psychiatric care	☐ Tonsillitis
☐ Chemotherapy	bleeding	☐ Rapid weight gain/loss	☐ Tuberculosis
☐ Circulatory problems	☐ Herpes	☐ Radiation treatment	☐ Ulcer/Colitis
☐ Cortisone treatments	☐ Hepatitis	☐ Respiratory disease	☐ Venereal disease

Is patient currently taking any medications? If Yes, list all:

_____

_____

Does patient have any drug allergies? If yes, list all:

_____

_____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

I authorize the benefit plan(s) listed on this form to pay to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all benefit submissions. I authorize the dentist to release any information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by a benefit plan. I consent to the use and disclosure of my protected health information to carry our healthcare operations, treatment and payment activities (HIPAA).

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

I have received copies of the Dental Materials Facts Sheet and HIPAA Privacy Practices_____