

MILLER - ALBRECHT - HESS, DDS
General Dentistry

110 MOREY DRIVE - MARYSVILLE, OHIO 43040
(937) 644-1311

Date _____

Pt. ID.# _____

Name

First Name _____ M.I. _____

Last Name _____

Name you prefer to be called _____

Address

Street _____ Apartment/ P.O. Box _____

City _____ State _____ Zip Code _____

Birthdate _____ Age _____

SS# _____

How do you prefer we contact you? _____

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

E-Mail _____

Check appropriate boxes

- Single Married Separated Divorced Widowed
 Male Female

Person to contact in case of emergency _____

Phone (____) _____

Name of Employer _____

Address of employer _____
Street _____ City _____ State/Zip _____

Phone of your employer (____) _____

Spouse Information

His/ Her Name _____ Employer _____

Work Phone (____) _____ SS# _____

Birthdate _____

Whom may we thank for referring you? _____

Primary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date of Employment _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Policy/ID# _____

In. Co. Address _____ City _____ State _____ Zip _____

Secondary Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date of Employment _____

Name of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID# _____

In. Co. Address _____ City _____ State _____ Zip _____

____ Initial I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Over Please

MEDICAL HISTORY

PATIENT NAME _____ DATE OF LAST DENTAL APPOINTMENT _____

Physician Name _____ Physician Phone Number _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	N/A	If yes, please explain:
Are you under a physician's care now?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Have you ever had a serious head or neck injury?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

If yes, please list

Do you use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you on a special diet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you use controlled substances?	Yes <input type="radio"/>	No <input type="radio"/>	N/A <input type="radio"/>
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Women: Are you: Pregnant / Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? **Please check if Yes**

- | | | | | |
|---|---|---|--|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Chest Pains | <input type="radio"/> Frequent Headaches | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Genital Herpes | <input type="radio"/> Kidney Problems | <input type="radio"/> Shingles |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Glaucoma | <input type="radio"/> Leukemia | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Convulsions | <input type="radio"/> Hay Fever | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Angina | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Diabetes | <input type="radio"/> Heart Murmur* | <input type="radio"/> Lung Disease | <input type="radio"/> Stomach/intestinal Disease |
| <input type="radio"/> Artificial Heart Valve* | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Pace Maker* | <input type="radio"/> Mitral Valve Prolapse* | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joint* | <input type="radio"/> Easily Winded | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Asthma | <input type="radio"/> Emphysema | <input type="radio"/> Hemophilia | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hepatitis A | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Radiation Treatments | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Excessive Thirst | <input type="radio"/> Herpes | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> High Blood Pressure | <input type="radio"/> Renal Dialysis | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Cough | <input type="radio"/> Hives or Rash | <input type="radio"/> Rheumatic Fever* | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Hypoglycemia | <input type="radio"/> Rheumatism | <input type="radio"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No N/A If yes, please explain:

Comments:

*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

_____ Initials Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within (90) days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.