adult

PATIENT INFORMATION & HEALTH HISTORY

stacy miller
DDS • MS

PLEASE PRINT

Date

PATIENT INFORMATION

NAME (LAST / FIRST / MIDDLE / LIKES TO BE CALLED) SS#

ADDRESS CITY STATE ZIP

DATE OF BIRTH AGE ☐ MALE ☐ FEMALE CELL PHONE HOME PHONE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED EMAIL

DENTIST PHYSICIAN REFERRED BY

MAIN CONCERN

RESPONSIBLE PARTY INFORMATION

NAME (LAST / FIRST / MIDDLE) ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

ADDRESS CITY STATE ZIP

HOW LONG AT THIS ADDRESS? HOME PHONE WORK PHONE EMAIL

SOCIAL SECURITY # DRIVER'S LICENSE # DATE OF BIRTH

EMPLOYER OCCUPATION HOW LONG EMPLOYED

SPOUSE'S NAME (LAST / FIRST / MIDDLE)

SOCIAL SECURITY # DRIVER'S LICENSE # DATE OF BIRTH

SPOUSE'S EMPLOYER OCCUPATION WORK PHONE

INSURANCE INFORMATION

INSURED'S NAME INSURED'S SOCIAL SECURITY #

INSURANCE COMPANY GROUP #

INSURANCE CO. ADDRESS PHONE #

DO YOU HAVE DUAL COVERAGE? ☐ YES ☐ NO If yes, please fill in below:

INSURED'S NAME INSURED'S SOCIAL SECURITY #

INSURANCE COMPANY GROUP #

INSURANCE CO. ADDRESS PHONE #

CONTACT INFORMATION

PHONE Home Work Cell EMAIL

BEST TIME AND PLACE TO CONTACT YOU

IN CASE OF EMERGENCY, PLEASE CONTACT: (Specify someone who does NOT live in your household.)

NAME RELATIONSHIP

PHONE Home Work Cell EMAIL

MEDICAL HISTORY

HAS THE PATIENT EVER HAD:

DIABETES	❑ YES ❑ NO	TUBERCULOSIS	❑ YES ❑ NO	ENDOCRINE/THYROID	❑ YES ❑ NO
KIDNEY TROUBLE	❑ YES ❑ NO	ANEMIA	❑ YES ❑ NO	PROLONGED BLEEDING	❑ YES ❑ NO
PNEUMONIA	❑ YES ❑ NO	EPILEPSY	❑ YES ❑ NO	HEPATITIS	❑ YES ❑ NO
HEART TROUBLE	❑ YES ❑ NO	ASTHMA	❑ YES ❑ NO	FAINTING/DIZZINESS	❑ YES ❑ NO
RHEUMATIC FEVER	❑ YES ❑ NO	ARTHRITIC CONDITION	❑ YES ❑ NO	CANCER	❑ YES ❑ NO

Do you have any other medical concerns? ❑ YES ❑ NO Explain.....

Are you currently taking any drug or medications? ❑ YES ❑ NO Please list.....

Are you currently taking Bisphosphonates? ❑ YES ❑ NO Which one?.....

Do you have arthritis? ❑ YES ❑ NO

Are you currently under the care of a physician? ❑ YES ❑ NO Why?.....

Do you use tobacco products? ❑ YES ❑ NO What type?.....

Do you use any controlled substance? ❑ YES ❑ NO Please list.....

Are you allergic to any of the following? ❑ Acrylic ❑ Nickel ❑ Latex ❑ Medications ❑ Pollens ❑ Other.....

Have you tested POSITIVE for HIV/AIDS? ❑ YES ❑ NO

Do you wear contact lenses? ❑ YES ❑ NO

Have your tonsils and adenoids been removed? ❑ YES ❑ NO At what age?.....

DENTAL HISTORY

Have you had any injuries to the face, mouth or teeth? ❑ YES ❑ NO Explain.....

Do you have any areas that trap food? ❑ YES ❑ NO

Do you have any problems with your speech? ❑ YES ❑ NO Explain.....

Do you breathe predominantly through your mouth? ❑ YES ❑ NO

Have you been informed of any missing /extra permanent teeth? ❑ YES ❑ NO

Have you had previous orthodontic examinations or treatment? ❑ YES ❑ NO

Have you had any periodontal treatment? ❑ YES ❑ NO

Have you had your wisdom teeth removed? ❑ YES ❑ NO At what age?.....

When did you last visit the general dentist?..... Is any dental work pending?.....

What is the reason for your orthodontic examination?.....

TMJ HISTORY

Have you ever had any discomfort or clicking in the jaw-joint near the ears? ❑ YES ❑ NO

Do you clench or grind your teeth? ❑ YES ❑ NO

Do you have frequent head or neck aches? ❑ YES ❑ NO

Do you have pain or ringing in the ears? ❑ YES ❑ NO

Has your jaw ever locked or slipped out of place? ❑ YES ❑ NO

Are your teeth sore or sensitive? ❑ YES ❑ NO

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 Dr. Miller of any changes in medical status.

Signature..... Date.....