

Medical History

Physician's Name _____ 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 dates _____

Women: Are you pregnant? Yes No Nursing? Yes No Taking birth control? Yes No

Mark with an (X) if you have had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease/malfunction | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Material allergies: | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Glaucoma | (wood, metal, chemicals) | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous problems | or ankles |
| <input type="checkbox"/> Bizphosphonate therapy | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid disease or |
| <input type="checkbox"/> Blood disease | Describe _____ | <input type="checkbox"/> Pacemaker or heart surgery | malfunction |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/abnormal bleeding | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis (type _____) | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rapid weight loss/gain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory disease | |

List any medication you are currently taking, if any:

Aspirin Daily Bizphosphonates Coumadin _____

List any drug allergies, if any:

Authorization

I have reviewed the information on this questionnaire, and attest that it is accurate to the best of my knowledge. I understand that Dr. Miller will use this information to help determine appropriate and healthful dental treatment. If there is any change in my medical status or medications, I understand that I am responsible for informing Dr. Miller.

I hereby authorize Dr. Miller to take any necessary radiographs, photographs, or any other diagnostic aids deemed appropriate to enable him to thoroughly diagnose my/my dependent's treatment needs. I authorize Dr. Miller to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my/my dependent's treatment. I authorize Dr. Miller to choose and employ such assistance as he deems fit. I understand the use of anesthetic agents embodies a certain risk.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I realize that it is a courtesy that Dr. Miller's office files my insurance for me and that they are in no way affiliated with my insurance company and cannot possibly know the benefits and limitations of every policy. **I understand that I am ultimately responsible for payment of services provided in this office for myself and my dependents, regardless of insurance benefits, and that payment is due at the times services are rendered.** The responsibility for any difference between actual charges and what the insurance company pays rests with the patient. I understand there is a \$30 fee for any returned checks. I understand that missed appointments and those cancelled with less than 24 hours notice may incur a broken appointment fee of 20% of the total fees scheduled for the allotted time, with a \$50 minimum fee. I understand that a finance charge of 2% monthly will be added to any balance over 60 days, with or without insurance coverage, unless other arrangements have been made with the office manager. Any accounts turned over to collections will incur a collection fee of 40% of the balance due. In the event that I default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Please note that the parent bringing in a child (under age 18) for treatment is the parent legally responsible for all fees incurred for the child's treatment, regardless of which parent is the insured.

Signature _____ Date _____

Payment is due in full at the time services are rendered.