Patient Information

Name____ Birthday_____________ SS#_______________
Last First M.I. Nickname
Address____
Street City State Zip Code
Home Phone_______________________ Work Phone____________________ Cell Phone_____________________
Email ______________________________________ Pharmacy (Name & Number)____________________________
Marital Status_____ Spouse's Name_____________________ Whom do we thank for referring you?_______________

Responsible Party Information (If other than yourself)

Name____ Birthday_____________ SS#_______________
Last First M.I. Nickname
Home Phone_______________________ Work Phone____________________ Cell Phone_____________________
Spouse's Name_________________________ Home Phone_________________ Work Phone___________________

Dental Insurance Information

Policy Holder Name____________________________________ Birthday_____________ SS#_______________
Last First M.I.
ID No.__________________________ Group No.______________________ Effect. Date of Ins.______________
Ins. CO.________________ Address____
Street City State Zip Code
Employer________________ Address____
Street City State Zip Code

Do You Have Dual Coverage ( ) Yes ( ) No If Yes, Complete the Following:

Policy Holder Name____________________________________ Birthday_____________ SS#_______________
Last First M.I.
ID No.__________________________ Group No.______________________ Effect. Date of Ins.______________
Ins. CO.________________ Address____
Street City State Zip Code
Employer________________ Address____
Street City State Zip Code

Emergency Notification Information

Name___________________ Address____ Phone No.___________
Street City State Zip Code

I will inform your office of any changes in my Insurance Coverage

______________________________ ______________________
Signature of Patient or Guardian **Date**

Medical History

Name_________________________ Date______________ General State of Health: **Good (__) Fair (__) Poor (__)**

Name/Address/Number of Physician____

Have you been under a physician's care during the past two years? ____________________

Have you been treated in the hospital during the past three years? ____________________

Have you had any **Major Surgery?** _______What/ When______________________

Do you or Have you been told to Premedicate before appointments?__________ **Do you take Blood Thinners?**__________

If Female: Are you pregnant? _______________ Nursing? _______________ On Birth Control?_______________

Do you or have you had any of the following?

Yes / No

( ) ( ) Aids / HIV+
( ) ( ) Arthritis
( ) ( ) Artificial Heart Valves
( ) ( ) Artificial Joints
( ) ( ) Asthma
( ) ( ) Bruise / Bleed Easy
( ) ( ) Cancer
( ) ( ) Chemotherapy
( ) ( ) Chest Pain / Angina
( ) ( ) Congenital Heart Lesions
( ) ( ) Diabetes
( ) ( ) Dry Mouth
( ) ( ) Emphysema / Bronchitis
( ) ( ) Epilepsy / Seizures
( ) ( ) Fainting / Dizziness
( ) ( ) Fibromyalgia
( ) ( ) Heart Problem / Murmur
( ) ( ) Heart Surgery
( ) ( ) Hepatitis A, B, C, D, E

Yes / No

( ) ( ) High Blood Pressure
( ) ( ) Irregular Heart Beat
( ) ( ) Kidney Problems
( ) ( ) Liver Disease
( ) ( ) Mitral Valve Prolapse
( ) ( ) Nervousness / Anxious
( ) ( ) Organ Transplant
( ) ( ) Pacemaker
( ) ( ) Persistent Cough
( ) ( ) Pneumonia
( ) ( ) Radiation Fever
( ) ( ) Rheumatic Fever
( ) ( ) Sickle Cell Anemia
( ) ( ) Sinus Problems
( ) ( ) Stroke
( ) ( ) Thyroid Disease
( ) ( ) Tobacco Use
( ) ( ) Tuberculosis / PPD+
( ) ( ) Venereal Disease

Do you have any Condition, Disease, or Problem not listed above?

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Do you have any medication allergies? If yes, please specify

Yes / No

( ) ( ) Antibiotics (Erythromycin/Tetracycline/Penicillin/Flagyl)
( ) ( ) Aspirin / Acetaminophen / Ibuprofen
( ) ( ) Codeine

Yes / No

( ) ( ) Dental Anesthetics
( ) ( ) Latex
( ) ( ) Sulfa

Any not listed ____

Please list all medications you are taking, including over the counter drugs and herbs____________________

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Your estimated insurance co-pay is expected when services are rendered, unless payment options have been arranged prior to treatment. All new patients are required to pay for their first visit in full unless we have discussed or received your insurance information prior to your appointment, in which you will only be expected to pay your estimated co-pay. We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed by you to your insurance carrier.

We are pleased to offer the following payment options:

- Cash or Check
- Visa, MasterCard, or American Express
- Care Credit (If approved, you have the option of 6 to 18 months interest free!)

Note: Please keep in mind that all balances of money owed are personal balances regardless of what your insurance company pays.

I agree that I am fully responsible for the total payment of all procedures performed in this office, this includes any treatment that is or is not a benefit of any dental insurance that I may have. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my health status. **We do require a 24 hour notice for canceled appointments**, anything less is considered a broken appointment. After a broken appointment, it is at our Doctor's discretion whether or not we will continue seeing you as a patient.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

Compound Authorization for Release of Information

Warren & Miller Dentistry is authorized to release ______________________________ protected health information to the entities listed below, as well as referring Dental/Medical offices. The purpose is to inform the patient or others in keeping with the patient's instructions.

Name: ____ Relationship to patient: ______________________________

Name: ____ Relationship to patient: ______________________________

Name: ____ Relationship to patient: ______________________________

I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, by sending a written notification to **Warren & Miller Dentistry**
I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

__________________________________ Date ________________

(Signature of Patient or Guardian)