DANIEL G. MILES, Jr., D.M.D.

Restorative & Cosmetic Dentistry

Patient's Name ______ Today's Date ______
Home Address ______ City ______ State ______ Zip ______
Home Phone ______ Work Phone ______ Soc. Sec. # ______
Sex: ☐ M ☐ F Date of Birth ______ Age ______ Driver's Lic # ______
Occupation ______ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Employer ______ Employer's Address ______
Guarantor of Account - Name ______ Phone ______
Address ______
If patient is a minor, we need: Mother's Birthdate ______ Father's Birthdate ______
Name of Spouse/Parent ______ Work Phone ______
Address of Spouse/Parent ______
Spouse's/Parent's Employer ______ Spouse's Soc. Sec. # ______
Referred to Us By ______
EMERGENCY INFORMATION: Name/Address/Phone of a relative not living with you ______

Dental Insurance

Primary Carrier

Insurance Co. Name ______ Insurance Co. Phone ______
Address (Street, City, State, Zip) ______
Group No. (Plan or Policy No.) ______ Insured's I.D. No. ______
Insured's Name ______ Relationship to Patient ______
Date of Birth ______ Insured's Soc. Sec. # ______
Insured's Employer Name ______ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance Co. Name ______ Insurance Co. Phone ______
Address (Street, City, State, Zip) ______
Group No. (Plan or Policy No.) ______ Insured's I.D. No. ______
Insured's Name ______ Relationship to Patient ______
Date of Birth ______ Insured's Soc. Sec. # ______
Insured's Employer Name ______ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name ______ Relationship to Patient ______
Soc. Sec. # ______ Phone ______
Driver's License No. ______ Date of Birth ______
Address (Street, City, State, Zip) ______
Employer ______ Work Phone ______

Dental History

Reason for today's visit ______
Are you currently in pain? ☐ Yes ☐ No
If so, please describe ______
Do you have any dental problems now? ☐ Yes ☐ No
If so, please describe ______
Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No
If so, please describe ______
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)
Date of last dental exam ______ Date of last cleaning ______ Date of last full mouth X-rays ______
Procedure(s) done at last dental visit ______
Previous dentist's name ______
City ______ State ______ Phone ______
Why are you changing dentists? ______
How often do you have dental examinations? ______ How often do you brush your teeth? ______
How often do you floss? ______ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft
What other dental aids do you use? (Electric toothbrush, toothpick, etc.) ______

Do you require antibiotics before dental treatment?	☐ Yes ☐ No	Do you have frequent headaches?	☐ Yes ☐ No
Do your gums ever bleed?	☐ Yes ☐ No	Do you clench or grind your teeth?	☐ Yes ☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes ☐ No	Are your teeth sensitive to heat/cold?	☐ Yes ☐ No
Do you bite your lips or cheeks frequently?	☐ Yes ☐ No	Do you still have your wisdom teeth?	☐ Yes ☐ No

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? ____________________

Hospital or Physician's Name ____________________ Phone ____________________

Hospital or Physician's City ____________________ State ____________________

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain ____________________

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? ____________________

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? ____________________

Do you use tobacco? ☐ Yes ☐ No   Do you use alcohol or any other controlled substances? ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No   Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes ☐ No	Diet (Special/Restricted)	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Alcohol/Drug Abuse	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Allergies or Hives	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Nervousness/Anxiety	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No	Psychiatric/Psychological Care	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Artificial Bones/Joints	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic/Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Shingles/Chicken Pox	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart (Surgery, Disease, Attack)	☐ Yes ☐ No	Sickle Cell Disease/Traits	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Snoring/Sleep Apnea	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	Hemophilia/Abnormal Bleeding	☐ Yes ☐ No	Stomach Problems/Ulcers	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Hepatitis A B C (circle)	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cold Sores/Herpes	☐ Yes ☐ No	High or Low Blood Pressure	☐ Yes ☐ No	Swollen Ankles	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Hospitalized for Any Reason	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Contact Lenses	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease/STD	☐ Yes ☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Jewelry/Metals	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Anesthetics (i.e. Novocaine)	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	Penicillin or Other Antibiotics	☐ Yes ☐ No	Other ____________	

Patient Signature ____________________

CONSENT TO TREATMENT: I consent to the performance of procedures, operations, and administration of anesthetics or other medications considered necessary or advisable by Dr. Daniel Miles and/or his assistants as may be selected by them.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies upon receipt of full or partial payment of account. We do not render our services on the basis that insurance companies will pay part or all of our fees.

PAYMENT TERMS: As consideration for the Doctor's rendering services to the Patient, the Patient or person responsible for the account agrees to pay all charges for services at the completion of such services. If payment is not received upon completion of treatment the Doctor may, at his discretion, after 30 days, place the unpaid account with an attorney or collection agent for collection. In the event an account is turned over for collection, the Patient or person responsible for the account agrees to pay an attorney's fee, court costs and any other reasonable costs of collection, and thereby waives all rights of exemption under the Constitution and the laws of Alabama.

SIGNED: ____________________ **Date** ____________________

PATIENT AND/OR RESPONSIBLE PARTY (IF A MINOR, PARENT OR GUARDIAN)