PATIENT INFORMATION:

Date:___/___/_____

Title: _____ First Name: _____ MI:_____ Last Name: _____

Nickname:_____ Birthdate: ____/____/_____ Gender: M / F Age: _____ Marital Status: _____

Address:_____City:_____ State:____ Zip code:_____

Primary Contact #: (_____)_____-_____ ext-_____ Home / Mobile / Work

Alternate Contact #: (_____)_____-_____ ext-_____ Home / Mobile / Work

Emergency Contact/#: _____ / (_____)_____-_____

Email: _____

Employer: _____ Occupation: _____

Referred by: _____ Orthodontist: _____ General Dentist: _____

Medical Doctor:_____ Phone: (_____)_____-_____

How did you hear about our office? _____

Have you ever been seen by Dr. Miller or Dr. Drab? Y / N

What is the reason for your visit to our office today? _____

Is this an accident or work related? No / Yes (if yes; explain):_____

I give my permission for clinical photographs, if requested by Dr. Miller or Dr. Drab _____ Y / N (please circle)

PERSON RESPONSIBLE FOR ACCOUNT (if other than above)***:***

Title: _____ First Name: _____ MI: _____ Last Name: _____

Relationship to Patient: Self / Spouse / Parent / Other (please specify): _____ DOB: _____

Address:_____City:_____ State:____ Zip code:_____

Primary Contact #: (_____)_____-_____ ext-_____ Home / Mobile / Work

Alternate Contact #: (_____)_____-_____ ext-_____ Home / Mobile / Work

Email: _____

Employer: _____ Occupation: _____

I authorize release of all information necessary to process my insurance claims. I assign all medical and dental benefits to which I am entitled to Drs. Miller and Drab. This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original. I have read the HIPPA policy. I understand that I am financially responsible for all charges. I have read this information and understand it.

Signature of patient or parent/legal guardian. Date Staff Witness

I give permission to this office to release any information about my account to: _____

Dental Insurance Information

Patient Name: _____Date of Birth: ____/____/____

Policy Owners Name: _____ Date of Birth: ____/____/_____

Insurance Company: _____ Phone: (____) _____

Policy Owners Employer: _____ Group #:_____

Member ID: _____ or SS#:_____

Medical Insurance Information

Policy Owners Name: _____ Date of Birth: ____/____/_____

Insurance Company: _____ Phone: (____) _____

Policy Owners Employer: _____ Group #:_____

Member ID: _____ or SS#:_____

If you have insurance, we will obtain an **estimate of your benefits** prior to scheduled procedures. The estimate is based on the information provided by your insurance and **is not a guarantee of benefits, coverage or payment.** We collect the estimated patient portion on the date of service.

All professional services are filed to your insurance as a **courtesy.** Any remaining balance after insurance processes will become patient responsibility. The amount your insurance allows for services rendered may be less than our office fees. Deductibles and co-insurance may attribute to receiving a statement after services are rendered and all claims have completed processing by your insurance.

***ONCE BENFITS ARE VERIFIED, PLEASE CONTACT:**

_____ / _____

NAME PHONE #

Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Gender: Male / Female Height: _____ Weight: _____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Are you now under a physician's care for a particular problem? (explain):_____ Y N
4. Have you **ever** had any serious illnesses, surgeries or hospitalizations? If so, describe: .....Y N

   _____

   _____
5. **LIST ANY MEDICATIONS (INCLUDING BLOOD THINNERS/ASPIRIN/FEN-PHEN/DIET PILLS)....Please list on next page.**
6. **HAVE YOU EVER BEEN ADVISED THAT YOU NEED ANTIBIOTICS FOR A HEART MURMUR OR JOINT REPLACEMENT?.....**Y N
7. Are you currently taking, or have taken biphosphonates (fosamax, zometa/reclast), and/or Prolia/Xgeva?.....Y N
   Please List:_____
8. Do you smoke or chew tobacco .....Y N
   How much per day? _____
9. Is there any past history of Alcohol or Chemical Dependency that may affect the care we provide you? Y N
10. Have you ever had any problem with local, intravenous, or general anesthesia?.....Y N
    Problems:_____
11. Have you ever had radiation or chemotherapy? .....Y N

FOR WOMEN ONLY

A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N

B. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some medications) may interfere with the effectiveness of oral contraceptives.

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR FOOD?.... Y / N .....(Please list below)

_____

_____

11. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Arthritis.....Y N
B. Artificial heart valves.....Y N
C. Asthma.....Y N
D. Bleeding disorders.....Y N
E. Chest pain.....Y N
F. Diabetes.....Y N
G. Heart Disease/CAD/Arrhythmias.....Y N
H. Heart murmur.....Y N
I. Hepatitis ……type:_____.....Y N
J. High blood pressure.....Y N
K. HIV / AIDS.....Y N
L. Jaw joint pain/TMJ.....Y N
M. Joint replacement.....Y N
N. Kidney disease.....Y N
O. Lung Disease/COPD.....Y N
P. Pacemaker.....Y N
Q. Nervous Disorders.....Y N
R. Rheumatic fever.....Y N
S. Seizures/epilepsy.....Y N
T. Stomach/intestinal disease.....Y N
U. Thyroid disease.....Y N
V. Tuberculosis.....Y N
W. Tumors/growths.....Y N
X. Are you taking methadone? (This can interact with anesthesia medicines).....Y N

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ _____ _____

Date Signature of Person Completing Health History Doctor's Initials

Pt: _____

MEDICATION LIST

Medication Name	Dosage / Frequency	Reason for use
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

EDUCATION FOR PATIENTS REGARDING OPIOID USE

The decision to take prescription opioids is your choice. Prescription opioids can be used to help relieve moderate to severe pain when recovering from a surgery. Medications are an important part of your treatment and you should work closely with your prescribing doctor to understand the risks and benefits of taking any medications, including opioids. Knowing your options for pain management is important. Pain relievers such as acetaminophen, ibuprofen and naproxen may be the best choice and have fewer risks and side effects. Opioid use can have a number of side effects such as:

- Nausea, vomiting or dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Itching and sweating
- Constipation
- Addiction
- Opioid overdose can cause slowed breathing and even be fatal

If you discuss all your pain management options and risks with your doctor and you decide taking a prescribed opioid is the best choice for your pain management:

- Understand all the risks and side effects of opioid use (Additional resources can be found on the CDC and FDA websites www.fda.gov and www.cdc.gov).
- Always take the prescribed opioid as directed by your prescribing doctor and never take more than your doctor ordered, or more frequently than your prescribing doctor ordered.
- Never use another person's prescription opioids or share, sell or trade your own prescription opioids.
- Do not take other medications or prescribed opioids from other doctors without informing them of any and all medications you are taking and any potential drug interactions.
- Report any and all medications and health issues to your prescribing doctors before taking opioids and bring the pill bottle with you to any hospital or doctor's visits.
- Report any addiction problem to your doctor.
- The prescribing doctor will prescribe an appropriate number of pills to manage your pain. If your medicine is lost, stolen or used up sooner than prescribed, your medication may not be replaced. If a refill is required, contact your doctor's office during normal business hours. No refills will be provided on nights, holidays or weekends.
- Properly dispose of any unused prescription opioids.

Your doctor may consult the state Prescription Drug Monitoring Program (PDMP) before prescribing you opioids.

My signature below acknowledges I have read and understand the information provided to me and my questions have been answered.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Print Patient's (or Legal Guardian's) Name/Relationship Date