After Hours Dental Care Patient Form

Patient Name:_____ Date: ___/___/_____

Gender (M/F) ___Marital Status:____ Birth Date:___/___/____S.S.#_____

Drivers License #:_____ E-mail:_____

Address: _____

Home Phone:_____Cell:_____Work:_____

How did you first hear about us? (Internet ad, friend, etc.)_____

Responsible Party:_____S.S.#_____

Birth Date:____/____/_____Employer:_____Phone:_____

Address:_____

Insurance Co:_____Phone:_____

Billing Address:_____

Do you have or have you had any of the following medical conditions?

Y N High Blood Pressure	Y N Heart Attack	Y N Heart Disease	Y N Anemia
Y N Heart Murmur	Y N HIV or Aids	Y N Emphysema	Y N Cancer
Y N Rheumatic Fever	Y N Pacemaker	Y N Diabetes	Y N Stroke
Y N Artificial Joint/Implant	Y N Fainting	Y N Seizures	Y N Asthma
Y N Hepatitis	Y N Glaucoma	Y N Arthritis	Y N Ulcers

Do you have any medical condition we need to know about?_____

_____

Are you allergic to any medications?_____

Are you taking any medications? _____

_____

Physicians Name:_____ Phone #:_____

Do you use tobacco?____ Alcohol?____ Other Drugs_____

Women: Are you pregnant?_____ Due Date: _____ Nursing?_____

What is your main dental concern today?_____

What is your pain level? 1 2 3 4 5 6 7 8 9 NONE

We will be happy to file your insurance for you. You will be responsible for paying your copayment at the time of service. You will also be responsible for any amount left unpaid by your insurance company.

I, _____consent to the dental procedures deemed necessary by Dr. Michael Miller. I certify I have read and understood the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be hazardous to my health. I have been given a copy of Dr. Miller's Privacy Policy.

Signature:_____Date:_____

Person to contact in case of emergency:_____

Phone #s_____Relationship to Patient:_____