Charlotte Prosthodontics

R. Bruce Miller, DDS, MS, FACP
Board Certified Prosthodontist

WELCOME TO OUR PRACTICE

Please Print

Date: ____________________

Name____

Last Name First Name Initial Preferred Name Social Security Number

Home #: _____________ Cell #: ______________ Work #: _______________ Email Address: ____________________

Street Address ____________________________________ City _____________________ State ____ Zip________

Sex: ☐M ☐F Age________ Birthday _____________________ ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Other

Employed By ____ Occupation _____________________

Spouse Name ____ Spouse Birthdate ________________

Spouse Employed by ____ Occupation _____________________

Who is responsible for this account? _______________________________ Relationship to Patient________________

In case of emergency, who should we notify? _____________________________ Phone _______________________

Whom may we thank for referring you? ____

DENTAL HISTORY

Last dental exam:___________Last dental x-rays:____________Times a day you brush?_____Times a week you floss?_____

Have you ever had trouble associated with a previous dental treatment?____

Do you have any existing dental problems? ____

○ Discomfort, clicking, or popping in jaw	○ Teeth grinding/ clenching	○ Stained teeth
○ Red, swollen, or bleeding gums	○ Ringing in ears	○ Locking jaw
○ A removable dental appliance	○ Broken/ chipped tooth	○ Bad breath
○ Blisters/ sores in or around mouth	○ Gum disease	○ Burning tongue/ lips
○ Prolonged bleeding from an injury/extraction	○ Lost/broken filling(s)	○ Toothache
○ Recent oral infections or sore throat	○ Food caught between teeth	○ Swelling/ lumps in mouth
○ Loose/ shifting teeth	○ Difficulty closing jaw	○ Difficulty opening jaw

My teeth are sensitive to: ○ Hot ○ Cold ○ Sweets ○ Biting

On a scale of 1-10, 1 being best, how would you rate your smile?____________ Do you wish your teeth were whiter?_________

Have you ever been told to pre-medicate prior to dental treatments? ☐ Yes ☐ No

What brand of toothbrush do you use?______________ Electric or manual? Soft, medium, or hard bristles?

Is there a history of tooth loss or gum disease in your family ☐Yes ☐No Who? ____________________________

MEDICAL HISTORY

Primary Care Physician____

Name Phone Number

General Dentist: ____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________

Do you have, or have you had, any of the following?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________

Is there anything else concerning your physical or mental health that we should be aware of? ☐Yes ☐No

I certify that I have read and understand the above. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian ______________ Reviewed by ______________ Date ______________

Financial Policies

For your convenience we accept cash, check, Visa, MasterCard and American Express. For large cases we have a financial planner who can advise you on the options we offer.

Missed Appointment/ Late Cancellation Policy

We try to be understanding about the need to change appointments with short notice. However, if a patient has three or more missed appointments or late cancellations (cancelled after 10am the previous work day), we will charge a service fee of $75.

3% interest on all past due account will be applied.
In the event that a check payment is returned a $30 fee will be applied

I hereby certify that I have read and understand the above policies, and that I acknowledge that I am responsible for any charges incurred by me with R. Bruce Miller DDS, MS. FACP

Patient Signature: ___________________________

Date: ___________________________

Dental Insurance Information- if you have a dental insurance card, please let us scan it into your file

The services we provide are to our patients. We will gladly submit insurance claims as a courtesy to our patients, but the patient is responsible for all charges. If there are any questions regarding treatment options or insurance reimbursement, we request that these questions be discussed prior to treatment. New patients will be expected to pay for services rendered if we cannot establish their insurance eligibility at the time of the first appointment. In this case, we will request that the insurance company send any payment directly to the patient.

Name of dental insurance company: ________________________
Group number: ______________________ Group name: ______________________
Primary subscriber name: ________________Subscriber Date of Birth:__________Subscriber ID number:__________
Claims mailing address: ____
____
Phone Number: ___________________

Health Insurance Portability and Accountability Act (HIPAA)

I authorize Dr. Miller, and his staff to release information pertaining to my dental treatment to my insurance company and to other dental specialists to whom they refer me.

Patient Signature: ___________________________

Date: ___________________________

The following section is optional

Designation of Personal Representative: I hereby designate the following individuals as my personal representative(s) and authorize Dr. Miller to release any verbal or written information about me to my personal representative(s) as may be needed to assist with my ongoing treatment. This designation and authorization will remain in effect until revoked by me in writing.

X_________________________________ _________________
(Signature of patient) Date

Personal Representative Name	Relationship to Patient	Contact Phone Number
X___________________________	________________	__________________
X___________________________	________________	__________________