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: O M O F Age___ Birthday ________ ODr. 0Mr. 0Mrs. 0Ms. 0Miss OOther

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? ______________________

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

My teeth are sensitive to: o Hot o Cold o Sweets o 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? 0 Yes O 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 0 Yes 0 No Who? ___________ _

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 accounts 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.

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 to 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______________ _	____________	____________

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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Answer	
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 ____________________