Brock C. Miller D.D.S.

Autauga Station Dental

PLEASE PRINT

PATIENT INFORMATION

PLEASE COMPLETE ALL THE REQUESTED INFORMATION IN INK

NAME: _____
Last First Middle

ADDRESS: _____
Number Street Apt. # or PO Box

_____
City, State, Zip

SSN#: _____ - _____ - _____ DL#: _____

TODAY'S DATE: _____

EMAIL ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

BIRTHDATE: _____

❑ Married ❑ Single ❑ Minor

❑ Male ❑ Female

PERSON RESPONSIBLE FOR THE ACCOUNT

NAME: _____
Last First Middle

ADDRESS: _____
Number Street Apt. # or PO Box

_____
City, State, Zip

SSN#: _____ - _____ - _____ DL#: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____
Number Street Apt. # or PO Box

_____
City, State, Zip

RELATIONSHIP TO PATIENT _____

HOME PHONE: _____

BIRTHDATE: _____

INSURANCE CO: _____

CONTRACT #: _____

GROUP #: _____

Please have your insurance card for us to copy!

AUTHORIZATION

I hereby authorize direct payment to **Autauga Station Dental** of any group insurance benefits otherwise payable to me. I accept full financial responsibility for all charges incurred at the time of service, regardless of any existing contract with my insurance company.

I authorize the dental staff to administer any medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this form and the dental/medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party Date

MINOR / CHILD CONSENT

As legal guardian of the minor listed above, I do hereby request and authorize the dental staff to perform all necessary dental services, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the dentist, whether or not I am present when treatment is rendered.

X _____
Patient or Responsible Party Date

Please turn the page

MEDICAL HISTORY

What is your impression of your present health? _____

Who is your personal physician? _____ Office location: _____

Date of last complete physical exam? _____ Doctor's Phone: _____

Please draw a circle around any of the following which you have had or have at present.

Heart Disease or Condition	Stroke	Hay Fever	Thyroid Disease	Venereal Disease (Syphilis Gonorrhea)
Angina Pectoris	Hemophilia	Emphysema	Glaucoma	Drug Addition
Frequent High Blood Pressure	Bruise Easily	Tuberculosis (TB)	Epilepsy or Seizures	Psychiatric Treatment
Shortness of Breath	Prolonged or Unusual Bleeding	Diabetes	Fainting or Dizzy Spells	Cancer
Swollen Ankles	Anemia	Ulcers	AIDS or AIDS Related Complex	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Sickle Cell Disease	Liver Disease	Cold Sores	Implant Prostheses
Heart Murmur	Arthritis	Jaundice (Other than at birth)	Genital Herpes	Unexplained Weight Loss
Rheumatic Fever	Asthma	Hepatitis		

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS *(If YES, please give details)*		
1. ARE YOU PRESENTLY, OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST YEAR?	YES	NO
2. ARE YOU PRESENTLY TAKING ANY MEDICINE OR DRUGS?	YES	NO
3. ARE YOU ALLERGIC TO ANY MEDICINE OR MATERIALS?	YES	NO
4. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?	YES	NO
5. HAVE YOU EVER EXPERIENCED ANY COMPLICATION OR ILLNESS FOLLOWING DENTAL TREATMENT?	YES	NO
6. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?	YES	NO
7. HAVE YOU EVER BEEN TOLD YOU WERE NOT ELIGIBLE TO BE A BLOOD DONOR?	YES	NO
8. DO YOU USE TOBACCO? (If YES, please circle and give frequency)	YES	NO
SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" Frequency: _____	YES	NO
9. **WOMEN:** ARE YOU PREGNANT? (If YES, please circle trimester number) **TRIMESTER** 1 2 3	YES	NO

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN IF PATIENT IS A MINOR)	DATE
X	X

DENTIST'S COMMENTS

Signature_____ Date: _____

MEDICAL UPDATES

Date	Exceptions NONE ❑	BP	Signature
Date	Exceptions NONE ❑	BP	Signature
Date	Exceptions NONE ❑	BP	Signature
Date	Exceptions NONE ❑	BP	Signature
Date	Exceptions NONE ❑	BP	Signature
Date	Exceptions NONE ❑	BP	Signature