THANK YOU FOR COMING TO SEE US TODAY – PLEASE LET US KNOW IF WE CAN BE OF ANY HELP AS YOU PROVIDE THE FOLLOWING INFORMATION

DR. BART MILLER
DDS • MS

DATE_____

NAME
MR DR
MRS MS_____
FIRST MIDDLE LAST PREFERRED NAME

MALE ☐ FEMALE ☐ BIRTHDATE_____ AGE _____ PHONE _____
month / day / year

ADDRESS_____
STREET CITY ZIPCODE

EMPLOYER/POSITION_____BUSINESS PHONE _____

SPOUSE'S NAME_____ SPOUSE'S SSN_____

EMPLOYER/POSITION_____BUSINESS PHONE_____

CELL PHONE(S)_____EMAIL_____

PATIENT'S DENTIST_____CITY_____

RELATIVES TREATED HERE_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHAT ARE YOUR MAIN CONCERNS TODAY? _____

_____

How would you describe your current physical health?_____

Are you allergic to any medications, metals, or latex?_____

Do you use any form of tobacco?_____

Are you currently taking any medications?_____

Are you currently under the care of a physician?_____

For women – Are you pregnant or do you suspect that you may be pregnant? _____YES _____NO

Do you require pre-medication for dental visits? _____YES _____NO _____ I'M NOT SURE

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Arthritis	Y N	Tonsilectomy	Y N	Heart Defect/Murmur	Y N	Snoring	Y N
Asthma	Y N	Compromised Immunity	Y N	Heart Disease/Attack	Y N	Mouthbreathing	Y N
Diabetes	Y N	Hypertension/Stroke	Y N	Prolonged Thumb Sucker	Y N		
Bleeding Disorders	Y N	Liver Disease/Hepatitis	Y N	Difficulty Breathing	Y N		
Cancer/Cancer Treatment	Y N	Rheumatic/Scarlet Fever	Y N	Headaches	Y N		

Please list any serious medical conditions that you have experienced? _____

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOU?

_____

I affirm that the information I have given above is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical/dental condition.

Signature Date