DENTISTRY WEST, SC

MARMAR MIAR, DDS

Thank you for choosing our office. In order to properly serve you, we will need the following information. All information is strictly confidential.

About You

Today's Date: _____

Mr./Mrs./Ms.: _____
Circle One — Last — First — M.I.

❑ Male ❑ Female I prefer to be called: _____

Birthdate: ____/____/____ SS#: _____

Home address: _____

_____
City — State — Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner

Home telephone #: _____

Work #: _____ Ext. # _____

Cell #: _____

Employer:

Occupation: _____ How long held? _____

Best time/place to reach you: _____

Whom may we thank for referring you? _____

Names of other family members seen by us: _____

_____

Previous/present dentist: _____
(Please circle)

Last visit date: _____

Spouse Information

Name: _____

Employer: _____

Work telephone #: _____ Ext. # _____

Birthdate: ____/____/____ SS #: _____

Dental Insurance

DENTAL INSURANCE 1ST COVERAGE

Employee name: _____

Employee date of birth: _____

Employer: _____ # Yrs. ____

Name of insurance co.: _____

Address: _____

_____

Telephone: _____

Program or policy #: _____

Union local or group: _____

Social security no.: _____

DENTAL INSURANCE 2ND COVERAGE

Employee name: _____

Employee date of birth: _____

Employer: _____ # Yrs. ____

Name of insurance co.: _____

Address: _____

_____

Telephone: _____

Program or policy #: _____

Union local or group: _____

Social security no.: _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I understand this information will be held in the strictest confidence and accept my responsibility to inform this office of any changes in my medical status.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information given today.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

Medical History

1. Physician's Name _____
   Address _____
2. Are you under a physician's care? ..... YES NO
   Reason _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in the "Comments" box to the right.)
5. Do you routinely take health related substances? ..... YES NO
6. Are you allergic to any medication or substances? ..... YES NO
7. Do you have any other allergies including latex? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you pregnant or suspect you may be? ..... YES NO
10. Do you use birth control medications? ..... YES NO
11. Have you ever been treated for or been told you might have heart disease? ..... YES NO
12. Have you ever had rheumatic fever? ..... YES NO
13. Are you aware of any heart murmurs? ..... YES NO
14. Do you have high or low blood pressure? ..... YES NO
15. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
16. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
17. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
18. Do you have any artificial joints / prosthesis / heart valve or a pacemaker? ..... YES NO
19. Do you have any blood disorders, such as anemia, leukemia, etc.? ..... YES NO
20. Have you ever bled excessively after being cut or injured? ..... YES NO
21. Do you have any stomach problems? ..... YES NO
22. Do you have any kidney problems? ..... YES NO
23. Do you have any liver problems? ..... YES NO
24. Are you diabetic? ..... YES NO
25. Do you have asthma? ..... YES NO
26. Do you have epilepsy or seizure disorders? ..... YES NO
27. Do you or have you had a venereal disease? ..... YES NO
28. Have you tested HIV positive? ..... YES NO
29. Do you have AIDS? ..... YES NO
30. Have you had or do you test positive for hepatitis? ..... YES NO
31. Do you or have you had T.B.? ..... YES NO
32. Do you smoke, chew, use snuff or any other form of tobacco? ..... YES NO
33. Do you consume alcoholic beverages? ..... YES NO
34. Have you had psychiatric treatment? ..... YES NO
35. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products ..... YES NO
36. Is there anything else we should know about your health that we have not covered in this form? ..... YES NO
    If so, explain _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

Medical History Update

Date:_____ No change_____ Date:_____ No change_____ Date:_____ No change_____ Date:_____ No change_____

Date:_____ No change_____ Date:_____ No change_____ Date:_____ No change_____ Date:_____ No change_____

Date:_____ Explain:_____ Initial:_____ Date:_____ Explain:_____ Initial:_____

Date:_____ Explain:_____ Initial:_____ Date:_____ Explain:_____ Initial:_____

Date:_____ Explain:_____ Initial:_____ Date:_____ Explain:_____ Initial:_____