



Miles Madison, DDS

Periodontics & Dental Implants

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CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME:	SEX: M F	BIRTHDATE:	SOC. SEC. NO:
HOME ADDRESS:		RESIDENCE PHONE:	CELL PHONE:
CITY:	STATE:	ZIP:	E-MAIL ADDRESS:
EMPLOYED BY:		OCCUPATION:	
BUSINESS ADDRESS:		BUSINESS PHONE:	
SPOUSE'S NAME:		EMPLOYED BY:	
SPOUSE'S BUSINESS ADDRESS:		BUSINESS PHONE:	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:			
REASON FOR TODAY'S VISIT:			

DENTAL INSURANCE INFORMATION

NAME OF PRIMARY DENTAL INSURANCE COMPANY:	NAME OF INSURED:	SOCIAL SECURITY OF INSURED:	GROUP NAME:	GROUP NO:
NAME OF SECONDARY DENTAL INSURANCE COMPANY:	NAME OF INSURED:	SOCIAL SECURITY OF INSURED:	GROUP NAME:	GROUP NO:

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to assign directly Dr. Madison all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of the signature on all my insurance admissions whether manual or electronic.

DATE: SIGNATURE:

CONSENT TO RELEASE INFORMATION: I authorize Dr. Madison to release, receive and share information with other health care providers, regarding my medical and dental information and services I have received.

DATE: SIGNATURE:

FINANCIAL AGREEMENT: I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I accept full financial responsibility for all charges not covered by insurance.

DATE: SIGNATURE:

CONFIDENTIAL HEALTH HISTORY

YOUR COMPLETE ANSWERS TO THE FOLLOWING QUESTIONS WILL HELP US BETTER EVALUATE YOUR PERIODONTAL NEEDS

NAME OF YOUR REGULAR PHYSICIAN:		PHONE:	
MO / YEAR OF YOUR LAST MEDICAL EXAMINATION:	ARE YOU IN GOOD HEALTH:		
PERSON TO NOTIFY IN CASE OF EMERGENCY:		PHONE:	
PLEASE LIST <u>ALL</u> MEDICATIONS OR HERBS YOU ARE CURRENTLY TAKING (Aspirin, Coumadine, Plavix, Fosomax, Ginko, etc.):			NONE
HAVE YOU EVER TAKEN PHEN FEN OR REDUX?			YES NO
HAVE YOU EVER BEEN TOLD TO PREMEDICATE WITH ANTIBIOTICS PRIOR TO HAVING ANY DENTAL PROCEDURE?			YES NO

ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING: Please Check All That Apply

Penicillin	Amoxicillin	Asprin	Codeine	Tetracycline	Erythromycin	Valium	Demerol
Barbiturates	Epinephrine	Iodine	Latex	Naproxen	Other: _____		

DO YOU USE TOBACCO OF ANY KIND? IF SO HOW MUCH _____ PER DAY PER WEEK PER MONTH PAST USE

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

YES	NO	YES	NO	YES	NO	YES	NO
	CHEST PAIN		BYPASS SURGERY		CANCER		HEADACHES
	SHORTNESS OF BREATH		HEART ATTACK		RADIATION/CHEMO THERAPY		MIGRAINES
	HIGH BLOOD PRESSURE		HIGH CHOLESTEROL		ASTHMA		EPILEPSY
	LOW BLOOD PRESSURE		HEPATITIS OR JAUNDICE		EMPHYSEMA		SEIZURES
	HEART VALVE PROSTHESIS		RECEIVED TRANSFUSION		SINUS TROUBLE		PSYCHIATRIC CARE
	MITRAL VALVE PROLAPSE		KIDNEY DISEASE		PERSISTENT COUGH		GLAUCOMA
	CONGENITAL HEART DEFECTS		IMPAIRED KIDNEY FUNCTION		TUBERCULOSIS		CONTACT LENSES
	RHEUMATIC FEVER		ESOPHAGEAL REFLUX		JOINT REPLACEMENT SURGERY		CHRONIC FATIGUE
	HEART MURMER		HIATAL HERNIA		ARTHRITIS		EXCESSIVE BLEEDING
	DAMAGED HEART VALVE		STOMACH ULCERS		CONNECTIVE TISSUE DISORDER		HIV POSITIVE/AIDS
	HEART ARRHYTHMIA		ANOREXIA OR BULEMIA		NEUROLOGICAL DISORDERS		STD (Herpes, etc.)
	CARDIAC PACEMAKER		DIABETES		STROKE		CHEMICAL DEPENDENCE

DO YOU HAVE ANY DISEASE, PROBLEM OR CONDITION NOT LISTED ABOVE? Please explain

FOR WOMEN, CHECK ALL THAT APPLY: I AM PREGNANT I AM NURSING I AM TAKING BIRTH CONTROL PILLS MENOPAUSAL

NAME OF YOUR REGULAR DENTIST:	FOR HOW LONG:
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HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 3 YEARS:
LESS THAN ONCE A YEAR ONCE A YEAR TWICE A YEAR THREE TIMES A YEAR FOUR TIMES A YEAR

ARE YOU CURRENTLY SATISFIED WITH THE CONDITION & APPEARANCE OF YOUR MOUTH AND TEETH
VERY SATISFIED SATISFIED IT'S OK SOMEWHAT DISSATISFIED VERY DISSATISFIED

DO YOU PRESENTLY HAVE ANY PAIN OR DISCOMFORT?	DO YOU HAVE ANY SENSITIVE TEETH?
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HAVE YOU EVER HAD BRACES? IF SO WHEN?

HOW OFTEN DO YOU FLOSS?	DO YOU CLENCH OR GRIND YOUR TEETH?
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DOES DENTAL TREATMENT MAKE YOU NERVOUS?
NO A LITTLE VERY EXTREMELY

I certify that the above statements are accurate and complete. SIGNATURE:	DATE:	REVIEWED BY:	DATE:
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