
 Name (Last) (First) (Middle) / / M F S M D W
 Date of Birth Sex Marital Status Social Security Number

 Home Address (Street) (City) (State) (Zip) Home Phone # Cell Phone#

 Home E-Mail Name of Employer Occupation (If full-time Student) Name of School/Grade

 Business Address (Street) (City) (State) (Zip Code) Business Phone Number

 Name of Responsible Party (same): _____ Spouse/Parent _____ Social Security _____
 The Responsible party holds the primary insurance coverage for you.

 Y/N
 Name of your Primary Dental Carrier Secondary Insurance? Spouse's Name Children's Names & Ages

 In case of Emergency, call: (Name, address, and Phone number of close relative *NOT* living at your home address.)

 General health (please check): EXCELLENT GOOD FAIR POOR Name of physician _____

 Physician's address _____ telephone number _____ date of last physical _____

 Are you pregnant? Yes No . If yes, expected delivery date: _____

 Do you smoke? Yes No . If yes, how much? _____

 Are you allergic to any medications? Yes No . If yes, names of medications _____

 Are you taking any medication now? Yes No . If yes, names of medications and problems for which they are taken:

 Medication 1) _____ Taken for _____ 3) _____
 2) _____ 4) _____

 Have you ever had (please circle specific diagnosis and check-mark appropriate boxes):

- | | | | | | | |
|--|-------------------------------|------------------------------|--|--------------------------------------|------------------------------|-----------------------------|
| Heart disease; Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> | AIDS; HIV; Drastic Weight loss; | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Mitral Valve Prolapse; Rheumatic fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Lymph node enlarge; swollen glands | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Abnormal blood pressure | High <input type="checkbox"/> | Low <input type="checkbox"/> | No <input type="checkbox"/> | Night Sweats, Frequent Diarrhea..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Congestive Heart Failure; Swollen Ankles | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Cancer; X-ray/Chemo treatments | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Heart Murmur; Congenital heart lesions | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Kidney disease; Ulcers, Anemia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Heart Valve; Pace Maker; Artificial Joints | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Autoimmune Dysfunction; Lupus | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Chest Pain / Angina | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Arthritis; Back Pain | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Shortness of breath upon exertion | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Tuberculosis or lung disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Frequent / Daily use of Aspirin | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Herbal Supplements St. Johns Wort | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Abnormal Bleeding; Easy to Bruise | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Alcohol / Drug Dependency | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Glaucoma, Contact lens | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sexually Transmitted Disease..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Diabetes; Frequent Urination; Dry Mouth | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Allergies: Metal; Latex; Anesthetics ... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Jaundice; Hepatitis; Liver Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Allergies: Antibiotics, Codiene; Aspirin | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Epilepsy; Seizures; Fainting; Neuro. Dysfunction | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Possibly Pregnant; Nursing | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Sinus Problems; Asthma; Emphysema | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Birth Control; Hormone Therapy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

 If you have entered "yes" to any of the above, please explain: _____

 What are your hobbies? Special Interests? _____

 How did you hear of Dr. Millner? _____

I authorize the release of information, related to my or my family's dental care, to my benefits carrier and assign my/our benefits to your office. I authorize you to sign my signature or write "signature on file" for me in the above matters and forbid my carrier from selectively validating any of my and/or my family members' authorizations to this office. If any one of my "authorizations/signatures" are deemed invalid by my carrier, I revoke all of my authorizations and request that the claim be returned unprocessed. Regardless of my dental benefit(s) plan, I recognize that I am ultimately responsible for dental expenses incurred by myself and/or my family in your office. I have authorized the dentist and his/her staff to diagnose, administer medications and dental treatment necessary for proper dental care. I have been given a copy of your "Office Policies", "Treatment Information" and " Home Care Information" sheet. I have had the opportunity to review them and ask questions. I understand and subscribe to their terms. The information and medical history provided by me on this page is correct to the best of my knowledge and I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions I have made in completing this form. I have reviewed and accept your HIPPA privacy policies. Unless I notify you in writing, I allow you to use any photographic, video or radiographic images for educational purposes. I acknowledge that payment in full is due prior to or at the time services are rendered unless I have assigned my dental benefits to your office and have preauthorized your office to place any unpaid balances on my credit card of file at your office. Additionally, all cosmetic dentistry must be paid in full prior to treatment. Furthermore, I agree to be charged a time proportionate fee (\$45 minimum) for any appointment that I cancel without 24 hour prior notice to your office.

 Signature of Responsible Party _____ Date _____ Print Name _____
 Relationship to patient _____ If patient is LESS THAN 18 YEARS OLD, parent or legal guardian MUST sign above.

DENTAL HEALTH and APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your *primary* concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

Is so, explain: _____

What, if anything, has happened in previous experiences at the dentist, that was reason not to return? _____

Do you have missing teeth? _____ If yes, have you had them replaced? _____

If you *have* had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____ What type of brush do you use? SOFT MED HARD

Do you avoid brushing any part of your mouth because of pain? Yes No . If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings? Yes No

Do you chew on only one side of your mouth? Yes No If yes, explain: _____

Do your gums feel tender or swollen? Yes No Do you usually have many cavities? ... Yes No

Do you clench or grind your jaws while sleeping or during the day? Yes No Do your jaws ever feel tired? Yes No

We respect your right to *choose* the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are *rarely* symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – *until* it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the *choices* available to achieve long-term health and beauty for your existing natural teeth. Please check **all** that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and *last* for a long time
- Spreading payments out over time may help me to achieve the excellent results I desire
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire
- I *am* interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now
- Although I am not interested in a plan for long-term dental health, I *do* desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please *rate* your smile from 1 to 10 (1= I hate my smile, 10= awesome) _____

Would you like to have whiter teeth? Yes No

If you had a *magic wand* what, if anything, would you change about your smile? _____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any *special* occasions coming up? _____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World-Class Smile, *often overnight*...

Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes No . If yes, please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At Yardley Family Dentistry, though **our focus is on appearance-related dentistry**, we can deliver 99% of your routine dental needs as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.

Warm regards,
Don E. Millner