

Marlo A. Miller, D.D.S., M.S.
ORTHODONTICS
Board Certified

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
First Middle Last

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Cell Phone_____ Home phone_____ Work phone _____

Email Address_____

Birthdate_____Social Security # _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Employer_____ Occupation_____ No. yrs. employed__

Spouse's Name_____ Cell Phone _____

Employer_____ Occupation_____ No. yrs. employed__

Social Security #_____ Birthdate_____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Relationship to Patient_____ Birthdate_____

Insurance Company_____ Group No._____ Member ID/SS #_____

Insurance Phone No._____ Do you have dual coverage? Yes ☐ No ☐ If Yes:

Insured's Name_____ Relationship to Patient_____ Birthdate_____

Insurance Company_____ Group No._____ Member ID/SS #_____

Insurance Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____
Street City Zip

Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please check Yes or No (If Yes, please fill in details)

Yes	No	
☐	☐	Are you taking any medication? _____
☐	☐	Are you allergic to any medication? _____
☐	☐	Do you have a history of a major illness? _____
☐	☐	Have you had any operations? _____
☐	☐	Have you ever been involved in a serious accident? _____
☐	☐	Have you ever smoked or chewed tobacco? _____
☐	☐	Have seen a physician in the last 12 months? Why? _____
		Female Patients only:
☐	☐	Are you pregnant? _____
☐	☐	Has menstruation started? _____

Please check any of the medical conditions below that you have had or currently have.

☐ Abnormal bleeding/Hemophilia	☐ Diabetes	☐ Hepatitis/Liver problems	☐ Pneumonia
☐ Anemia	☐ Dizziness	☐ Herpes	☐ LATEX allergy
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Radiation/Chemotherapy
☐ Asthma or Hayfever	☐ Gastrointestinal Disorders	☐ HIV / Aids	☐ Rheumatic Fever
☐ Bone Disorders	☐ Heart Problems	☐ Kidney problems	☐ Tuberculosis
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Nervous Disorders	☐ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes	No	
☐	☐	Are you presently in any dental pain? _____
☐	☐	Have you ever experienced any unfavorable reaction to dentistry? _____
☐	☐	Have your wisdom teeth been removed? _____
☐	☐	Have you ever lost or chipped any teeth? _____
☐	☐	Have there been any injuries to face, mouth, or teeth? _____
☐	☐	Is any part of your mouth sensitive to temperature? Where? _____
☐	☐	Is any part of your mouth sensitive to pressure? Where? _____
☐	☐	Do your gums bleed when you brush? _____
☐	☐	Do you have any type of thumb or tongue habit? _____
☐	☐	Are you a mouth breather? _____
☐	☐	Have you ever seen an orthodontist? If yes, who and when? _____
☐	☐	What is your attitude toward receiving orthodontic treatment? _____
☐	☐	Has anyone in your family received orthodontic treatment? _____
		How did they feel about the result? _____
☐	☐	Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
☐	☐	Are you aware of your jaw clicking or popping? _____
☐	☐	Are you aware of clenching your teeth during the day? _____
☐	☐	Have you ever been told that you grind your teeth? _____
☐	☐	Do you have "tension" headaches? _____
☐	☐	Have you ever experienced chronic ringing in your ears? _____
☐	☐	Are you aware that appointments will be during work hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Marlo Miller to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

Dr. Marlo Miller DDS MS Orthodontic Office

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Patient Photo Release Form

I hereby authorize Marlo A. Miller, D.D.S., M.S. to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, social media, magazines, and newspapers, and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or as part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

____ I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Exceptions:

____ I do not wish to have my first name shown or released

____ I only agree to have my face shown without any identifying features (e.g., eyes blurred out, etc.)

____ I do not wish to have my face shown at all

____ I only agree to have my teeth shown without any identifying features

____ I do not wish to have my photos used at all

Patient Name _____

Patient / Guardian Signature _____

Date_____