R. Stephen Miller, DDS & Camillo F. Fontana, DDS
1815 Clinton Ave South, Suite 640
Rochester, NY 14618
(585) 442-0990

Date_____

Name _____ Date of Birth _____

Social Security # _____Home# _____Cell #_____

Address _____City _____ Zip_____

Email _____

Employer _____Work # _____

Spouse's Name _____Employer _____ Work# _____

Is there another authorized person that we may share medical information with? Please include telephone numbers:

_____

_____

Name and Address of person responsible for payment other than yourself (parent/guardian) _____

_____Social Security #_____

Referred to our office by _____

Insurance and Financial Information

Insurance Company Name and address _____

Subscriber's Name _____ Patient's Relationship to Subscriber _____ Subscriber DOB _____

Subscriber's SSN _____ Group/Program Number _____ Employer _____

Secondary Dental Coverage (if applicable)

Insurance Company Name and address _____

Subscriber's Name _____ Patient's Relationship to Subscriber _____ Subscriber DOB _____

Subscriber's SSN _____ Group/Program Number _____ Employer _____

Assignment and Release:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____

Dental/Health History

Date _____

Previous Dentist_____ Date of most recent dental exam _____

Date of most recent x-rays _____ Immediate Dental Concerns? _____

Medical History

Name, Address and phone # of Physician _____

Date of last Physical Exam _____ General Health _____good _____ fair _____ poor

Have you or ever had and allergic reaction to:

- Aspirin, ibuprofen, acetaminophen, codeine
- Erythromycin
- Sulpha
- Fluoride
- Latex
- Other (including foods)_____
  _____
- Penicillin
- Tetracycline
- Local Anesthetic

Do you have a history of or been treated for:		Any lumps, sores or swelling	
Heart Problems, cardiac stent within last six months	___Y ___N	in mouth (herpes)	___Y___N
History of infective endocarditis	___Y ___N	Viral Infections, cold sores	___Y___N
Artificial heart valve, repaired heart defect	___Y ___N	Hepatitis (type ___)	___Y___N
Pacemaker or implantable defibrillator	___Y ___N	HIV/Aids	___Y___N
Artificial prosthesis(heart or joint)	___Y ___N	Tumor, abnormal growth	___Y___N
Rheumatic or scarlet fever	___Y ___N	Radiation therapy	___Y___N
High or Low Blood Pressure	___Y ___N	Chemotherapy	___Y___N
Stroke	___Y ___N	Hospitalization or surgeries	___Y___N
Anemia or blood disorder	___Y ___N	Epilepsy, convulsions, seizures	___Y___N
Are you subject or prolonged bleeding	___Y ___N	Neurological problems	___Y___N
Emphysema, sarcoidosis	___Y ___N	Hives, skin rash or hay fever	___Y___N
Glaucoma	___Y___N	**Are You :**	
Tuberculosis	___ Y___N	Presently being treated for any	
Asthma	___ Y___N	other illness	___Y___N
Head or neck injuries	___Y___N	Aware of a change in your	
Breathing or sleep problems (i.e. snoring, sinus)	___ Y___N	health	___Y___N
Kidney disease	___ Y___N	Subject to frequent headaches	___Y___N
Liver disease	___ Y___N	Having pain /clicking in jaw	___Y___N
Jaundice	___ Y___N	Having face, neck, shoulder pain	___Y___N
Thyroid, parathyroid disease or calcium deficiency	___ Y___N	A smoker or previous smoker	___Y___N
Having face, neck, shoulder pain	___Y___N	Have a heavy or persistent cough	___Y___N
Diabetes	___ Y___N	Had unintentional weight loss	___Y___N
Stomach or duodenal ulcer	___ Y___N	Being advised to pre-medicate prior	
Digestive disorders (i.e. gastric reflux)	___ Y___N	to dental treatment	___Y___N
Osteoporosis/osteopenia (i.e. taking bisphosphonates)	___ Y___N	Currently pregnant (due ____)	___Y___N
Arthritis	___Y___N		
Are you currently under any special care at this time?	**___Y __ N**	**If yes, please explain** _____	

_____

Please list all current medications: _____
_____
_____
_____

_____
Patient Signature