

MILES OF SMILES DENTAL CENTER

Shana R. Warren-Byers, D.D.S.

1636 Pulaski Pike, Suite B * Huntsville, AL 35816 * Phone (256) 539-3373

PATIENT INFO

Patient Name _____

Billing Address _____ Apt # _____

City State Zip Sex: **M / F** Age _____

Home Address _____ Same as Above? YES / NO

City State Zip

Home Phone (_____) _____ - _____ Work (_____) _____ - _____

Cell Phone (_____) _____ - _____ Email _____

D.O.B. ____ / ____ / ____ **Single Married Widowed Separated Divorced**

Social Security # _____ - _____ - _____ DL# _____ (_____)
State

Patient Occupation: _____ Employer _____

Today's payment? **Cash Credit Card Check**

Is patient covered by dental insurance? **YES / NO**

DENTAL INSURANCE

Insured's Name _____

Insurance Company Name _____ Group # _____

Member/ Policy # _____

Insured's Address _____ Apartment # _____

City State Zip SS# _____ - _____ - _____

Home Phone (_____) _____ - _____ Work (_____) _____ - _____

D.O.B. ____ / ____ / ____ Relationship to Patient _____

Insured's Employer _____ Address _____

Employer's Phone (_____) _____ - _____ Location _____

PLEASE COMPLETE REVERSE SIDE

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Please list any family members seen at this office.

DENTAL HISTORY

Reason for today's visit _____

Last Dental visit _____ Reason for visit _____

HEALTH HISTORY

Physicians Name _____

Date of Last Medical Visit _____

Who may we thank for referring you? _____

Referred from: Phonebook TV Ad Billboard Print Ad Radio Other

If Student:

School Name _____ School Dorm _____ Room # _____

STUDENTS: Please provide complete PERMANENT HOME address and phone number.

Permanent Home

Address _____ Apartment # _____

_____ Phone (_____) _____ - _____
City State Zip

For Office Use Only (below this line):

Effective Date _____ Fiscal Year ____/____ to ____/____

Yearly Maximum _____ How much of the yearly max has been used? _____

Yearly Deductible _____ Has deductible been met? _____

Coverage's: Preventive _____ % Subject to the **deductible**? _____
Basic _____ % Are **emergencies** Prev. or Basic? _____
Major _____ % Waiting period? _____
Endo _____ %
Perio _____ % Last PAN _____
OMS _____ % Last Full Mouth X-ray _____

Is there a missing tooth clause? Yes No

Ins Co. Contact _____

Verified by: _____ Date _____

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HEALTH HISTORY:

Place a circle "Yes" or "No" to indicate if you have had any of the following:

AIDS	Yes	No	Epilepsy/Seizures	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Fainting/Dizziness	Yes	No	Respiratory Disease	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Artificial Valves	Yes	No	Headaches	Yes	No	Rheumatism	Yes	No
Artificial Joints	Yes	No	Head Injuries	Yes	No	Scarlet Fever	Yes	No
Asthma	Yes	No	Heart Attack	Yes	No	Shortness of Breath	Yes	No
Attn Deficit (ADD)	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Back Problems	Yes	No	Heart Problems	Yes	No	Smoker	Yes	No
Bleeding Problems	Yes	No	Hepatitis (Type____)	Yes	No	Speech Impediment	Yes	No
Breathing Problems	Yes	No	Herpes	Yes	No	Stomach Problems	Yes	No
Blood Disease	Yes	No	High blood pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	HIV positive	Yes	No	Swelling Feet/Ankles	Yes	No
Chemical Dependency	Yes	No	Insulin Dependency	Yes	No	Thyroid Problems	Yes	No
Chemotherapy	Yes	No	Jaundice	Yes	No	Tonsillitis	Yes	No
Circulatory Problems	Yes	No	Jaw Pain	Yes	No	TMJ Issues	Yes	No
Clinical Depression	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Currently Pregnant	Yes	No	Liver Disease	Yes	No	Tumors/Growths	Yes	No
Currently Nursing	Yes	No	Low Blood Pressure	Yes	No	Ulcer	Yes	No
Cough, Persistent			Mental Disorders	Yes	No	Uses Alcohol	Yes	No
or Bloody	Yes	No	Mitral Valve Prolapse	Yes	No	Uses Drugs	Yes	No
Diabetes	Yes	No	Nervous Problems	Yes	No	Unexplained Weight Loss	Yes	No
Eating Disorder	Yes	No	Pacemaker	Yes	No	Veneral Disease	Yes	No
Emphysema	Yes	No	Psychiatric Care	Yes	No	Wear Contact Lenses	Yes	No

Are there any other health/medical conditions that we should know about?

Have you ever been told by a dentist or medical doctor that you need to be premedicated prior to dental treatment? Yes or No

Reason (if yes): _____

MEDICATIONS:

List medications you are **currently taking**:

_____ taken for _____
Condition

_____ taken for _____
Condition

_____ taken for _____
Condition

_____ taken for _____
Condition

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Condition

ALLERGIES: (Please circle or list)

Aspirin	Barbiturates	Codeine
Iodine	Latex	Local Anesthesia
Penicillin	Sulfa	Other _____

ASSIGNMENT & RELEASE

I certify that the health history is correct, to the best of my knowledge.

I, the undersigned certify that I (or my dependent) have dental insurance coverage and assign directly to Dr. Byers or Miles of Smiles Dental Center all insurance 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 insurance and am liable for all collection and/or attorney's fees from nonpayment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that a specific amount of time has been set aside by the dentist for each of my appointments. Without 24 hours advance notice of cancellation, the dentist is unable to use this time allotted for my treatment for other patients, some of which have dental emergencies. Therefore, without 24 hour prior notice, there will be a charge for broken appointments.

I permit the dentist and/or dental professional staff to act in my or my dependent's best interest, which may include providing emergency dental treatment, as necessary, to relieve pain/discomfort, infection, or other emergency situations.

Responsible Party's Signature

Relationship to Patient

Date

PLEASE PROVIDE A COPY OF THE RESPONSIBLE PARTY'S DRIVER'S LICENSE OR PICTURE I.D. AND INSURANCE CARD.