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 INFORMATION

Patient Name ____

Address ____ Apartment # _________

________________________ _________ ______________ Sex: **M** / **F** Age ______

City State Zip

D.O.B. _____ /_____ /_____ Social Security # ______-_____-________

Home Phone (______)______ - _________

Mother or Guardian ____

Address ____ Apartment # _________

________________________ _________ ______________

City State Zip

Home Phone (______)______ - _________ Work (______)______ - _________

Cell Phone (______)______ - _________ Email ________________________________

D.O.B. _____ /_____ /_____ Social Security # ______-_____-________

Employer ____________________ Employer's Address ___________________________

________________________ _______ ____________ (______)______ - _________

City State Zip Phone

Father or Guardian ____

Address ____ Apartment # _________

________________________ _________ ______________

City State Zip

Home Phone (______)______ - _________ Work (______)______ - _________

Cell Phone (______)______ - _________ Email ________________________________

D.O.B. _____ /_____ /_____ Social Security # ______-_____-________

Employer ____________________ Employer's Address ___________________________

________________________ _______ ____________ (______)______ - _________

City State Zip Phone

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Please list any family members seen at this office.

_________________________ _____________________ ____________________

Who may we thank for referring you? ___________________________________

Referred from: Phonebook TV Ad Billboard Print Ad Radio Other

Today's payment? **Cash** **Credit Card** **Check**
Is patient covered by dental insurance? **YES** / **NO**
Is the patient covered by Medicaid? **YES / NO**
Does the patient have dental insurance in addition to Medicaid? **YES / NO**

DENTAL INSURANCE
Insured's Name ____

Insurance Company Name____________________________ Group # _______________

Member/ Policy # ____

Insured's Address _______________________________________ Apartment # _______

________________________ ________ ______________ SS# _____-____-________
City State Zip

Home Phone (______)______ - _________ Work (______)______ - _________

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

Insured's Employer ________________ Employer's Address _______________________

________________________ _______ ____________ (______)______ - _________
City State Zip Work phone

DENTAL HISTORY
Reason for today's visit ____

Last dental visit ____

HEALTH HISTORY
Physicians Name ____

Date of Last Visit ____

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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**	Speech Impediment	**Yes**	**No**
Bleeding Problems	**Yes**	**No**	Hepatitis (Type____)	**Yes**	**No**	Special diet	**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**	Venereal Disease	**Yes**	**No**
Emphysema	**Yes**	**No**	Psychiatric Care	**Yes**	**No**	Wear Contact Lenses	**Yes**	**No**

Any other health/medical conditions that we should know about? Please list

________________________________ ______________________________

MEDICATIONS:
List medications your are **currently taking**:

________________________________ taken for ________________________
Condition

________________________________ taken for ________________________
Condition

________________________________ taken for ________________________
Condition

________________________________ taken for ________________________
Condition

ALLERGIES: (Please circle or list)

Aspirin	Local Anesthesia	Barbiturates	Penicillin
Codeine	Sulfa	Iodine	Latex

Other_____________________

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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.

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 __________% Is **preventive** work subject to the **deductible**? _________
Basic __________% Are **emergencies** Preventive or Basic? ______________
Major __________% Is there a waiting period for major work? __________
Endo __________ %
Perio __________ % Last PAN __________
OMS __________ % Last Full Mouth X-ray _________
Is there a missing tooth clause? Yes No
Ins Co. Contact ____

Verified by: __________________ Date ________________