Welcome to Mircale Dental

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

Email Address: _____

Name: _____
LAST FIRST MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Home Address: _____
APT/CONDO#

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: _____ Pager / Cell #: _____

Work #: _____ Ext: ___ DL #: _____

EMPLOYER: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are the best time to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(PLEASE CIRCLE)

Last Visit Date: _____

2 SPOUSE INFORMATION

His or Her Name: _____

Employer: _____

Work #: _____ **Ext #:** _____ **DL #:** _____

Birthdate: _____ **SS#:** _____

Person Responsible for Account:

Work #: _____ **Ext #:** _____ **Home #:** _____

Billing Address: _____

Relation: _____

Employer: _____ **DL #:** _____

3 DENTAL INSURANCE

Primary Dental Insurance:

Insurance Co.Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: _____ **Insured's ID #:** _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance:

Insurance Co.Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ **Relation:** _____

Insured's Birthdate: _____ **Insured's ID #:** _____

Insured's Employer: _____

Employer's Address: _____

Emergency Contact:

His or Her Name: _____

Relation: _____

Work #: _____

Home #: _____

Please continue to fill out this form completely. The better we communicate, the better we can care for you.

4 MEDICAL HISTORY

Physician's Name: _____

Physician's #: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over the counter or supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen Fen? ☐ Yes ☐ No

Are you taking asprin / blood thinner on a daily basis? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems? (please circle options that applies)

Y N	Anemia / Radiation treatment	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Bones / Joints / Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High / Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for any reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Drug / Alcohol Abuse	Y N	Severe / Frequent Headaches
Y N	Emphysema / Glaucoma	Y N	Shingles
Y N	Epilepsy / Seizures / Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following:

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / materials that you are allergic to:

_____

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problems associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsilbility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Intitals: _____ Date: _____

Doctor's Comments: _____

Date: _____ Comments: _____ Signature: _____