Miller Family Dentistry, LLC
"Committed to providing excellent dental care for patients of all ages"
435 Limekiln Drive, Chambersburg, Pennsylvania 17201
Phone 717.267.3922 Fax 717.267.3202

Welcome To Our Office

Our goal is to provide you comfortable, comprehensive and convenient dental care. We will ensure you have every question answered regarding your dental treatment. We constantly strive to improve all aspects of care that we provide to you. If you are ever concerned with the care you are receiving, please contact Dr. Miller or our staff so we may achieve our goals for you.

Patient Information

Name ❑Mr. ❑Mrs. ❑Ms. _____ _____
First *MI* *Last* *Preferred Name*

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed

Street Address _____

City _____ State _____ Zip _____

Phone# home _____ cell _____ work _____
E-mail address _____

Social Security Number _____ Date of Birth _____ Age_____
How would you like us to confirm your appointments? (select as many
❑Mail ❑E-mail ❑Phone (❑home ❑work ❑cell) ❑Text

Whom may we contact in case of emergency? _____ Phone _____

Whom may we thank for referring you? _____ Phone _____

Do you have dental insurance? ❑Yes ❑No **(if yes please fill out below information)**

Primary Insurance

Subscriber Name _____
SSN _____ *DOB* _____
(If different from patient information)
*Relationship to Patient*_____
Employer _____
Occupation _____
Insurance Company _____
Group Number _____
Member ID Number _____

Secondary Insurance

Subscriber Name _____
SSN _____ *DOB* _____
(If different from patient information)
*Relationship to Patient*_____
Employer _____
Occupation _____
Insurance Company _____
Group Number _____
Member ID Number _____

Medical History

(FRONT AND BACK)

General Health: (check box) ❑Excellent ❑Good ❑Fair Date of last physical_____

Physician's Name _____ Phone _____

Answers to the following are for our records and remain confidential.

Are you under current medical treatment? ❑Yes ❑No

If yes, please explain: _____

Are you currently taking any medication or herbal supplements? ❑Yes ❑No

If yes, please list all prescription and non-prescription medications, including vitamins and supplements on medication log *(see reverse page).*

Do you have allergies or adverse reaction to drugs? ❑Yes ❑No

If yes, please list drug and reaction: _____

_____

Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? ❑Yes ❑No

Are you on a special diet? ❑Yes ❑No

Have you lost or gained more than 10 pounds in the past year? ❑Yes ❑No

Do you use any form of tobacco? ❑Yes ❑No

What Type (please circle) Cigarettes Cigars Snuff Chew How much? _____

Are you interested in quitting? ❑Yes ❑No

Do you consume alcohol? ❑Yes ❑No If yes, how much per week on average? _____

Women, are you: (please circle) Pregnant Nursing On Hormone Therapy Taking Birth Control

Heart Disease	❑Yes	❑No	Respiratory Disease	❑Yes	❑No
Pacemaker	❑Yes	❑No	Asthma	❑Yes	❑No
High Blood Pressure	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Stroke	❑Yes	❑No	Bleeding Problems	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Latex Sensitivity	❑Yes	❑No
Other Heart Ailment	❑Yes	❑No	Organ Transplant	❑Yes	❑No
Cancer	❑Yes	❑No	Caffeine Dependency	❑Yes	❑No
Chemo/Radiation Therapy	❑Yes	❑No	Alcohol Dependency	❑Yes	❑No
Major Operations	❑Yes	❑No	HIV or AIDS	❑Yes	❑No
Arthritis	❑Yes	❑No	Psychologic/Psychiatric Treatment	❑Yes	❑No
Artificial Joints	❑Yes	❑No			
Liver Disease	❑Yes	❑No	Do you have a disease or condition not listed	❑Yes	❑No
Hepatitis	❑Yes	❑No	If yes, please explain:		
Kidney Disease	❑Yes	❑No			
Diabetes	❑Yes	❑No			
Family History Diabetes	❑Yes	❑No			
Intestinal Disease	❑Yes	❑No			
Gastric Reflux	❑Yes	❑No			

MEDICATION NAME	PRESCRIBED FOR	DOSAGE

Dental History

(FRONT AND BACK)

What is your immediate dental concern or like us to address today?

_____

Do you have dental pain now? _____

When was your last dental visit? _____

What was done at that appointment? _____

When: Was your last cleaning and exam? _____ Were your last dental x-rays taken? _____

Unfavorable dental experiences ❑

Dental fears ❑

Preference for no dental anesthetic ❑

Problems with effectiveness of or bad reactions to dental anesthetic ❑

Orthodontic treatment (braces) ❑

When _____

Bleeding gums ❑

Habitual chewing of hard substances i.e. ice, popcorn kernels ❑

Part of your mouth sensitive to temperature ❑

Lumps or bumps on head or neck ❑

Dry mouth ❑

Do you have a sugar or soda pop habit ❑

Unpleasant taste or odor in your mouth ❑

Viral infection or cold sores ❑

Jaw Problems (TMJ) ❑

Difficulty opening your mouth widely ❑

Stiff or sore head, neck or shoulder muscles ❑

Do you wake up with tooth or jaw pain? ❑

Tension headaches ❑

Clench or grind your teeth ❑

Jaw clicking or popping ❑

Any oral appliances ❑

Any removable teeth ❑

Family history of diabetes ❑

Parents who have lost teeth or had gum disease ❑

Noticed loose teeth or a change in your bite ❑

Breath through your mouth while awake or sleep? ❑

How often do you brush? _____Floss? _____

Other oral health aids: _____

Dental History Continued

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/or pain to fix down the road?

❑ Yes ❑ No

What do you value most in a dental office? Please write answer below.

Cosmetic– You most value how your teeth look (straight, white, etc.)

Function– You most value an ability to enjoy your favorite foods & drinks. You do not want to be limited to eating on one side/area.

Comfort– You most value NOT being in pain or having any tooth or gum sensitivities.

Example: I can't eat this anymore because it hurts or is sensitive

Longevity– You most value the ability to have your natural teeth forever. You expect the treatment you have completed to last forever.

_____

_____

What is the most important objection/obstacle you have to visiting a dental office? Please write answer below.

No objections or obstacles– Schedule and keep routine visits every 6 months as recommended. No dental fears or concerns with attending dental appointments.

Time– Having appointment times that suite your schedule with work and day to day activities.

Budget– Not having the finances to invest in dental treatment.

Lack of Trust– Unfavorable past dental experiences. Not given information on or reason towards treatment. Recommending treatment that is NOT necessary in improving dental health.

Lack of Urgency– Nothing has caused pain or discomfort so there has not been a reason to see a dentist. Believing pain or discomfort that may be present is "livable" or "manageable" without seeing a dentist.

_____

_____

How important is it for you to keep your teeth for the rest of your life? (circle one)

Not important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile or bite if you could? _____