Timothy H. Mihle, D.D.S.

Patient Information: **Date:**_____

Name:

_____
Last First M Date of Birth SS#

Circle:

Married Widowed Single Minor Male Female

Address:_____
Street Apt# City State Zip

Mailing Address:_____
Street/P.O. Box Apt# City State Zip

Telephone_____
Home Work Cell

E-Mail:_____

If the patient is under 18 years of age:

Name of Parent bringing child to today's appointment:

_____SS#_____

Mailing Address:_____
Street/P.O. Box Apt# City State Zip

Telephone:_____
Home Work Cell

Dental Insurance Information:

Primary Insured Member:

Name_____SS#_____Date of Birth_____

Primary Dental Insurance Co._____
Name Group# Address Telephone

Secondary Insured Member

Name_____SS#_____Date of Birth_____

Secondary Dental Insurance Co._____
Name Group # Address Telephone

TIMOTHY H. MIHLE, D.D.S, P.L.L.C

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECIEVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Y	N
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM _____		
4. PHYSICIANS NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? PLEASE EXPLAIN _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S)? INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING? _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
9. DO YOU BRUISE EASILY?	☐	☐
10 HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
12. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐	☐
13. DO YOU / HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
14. ARE YOU PRESENTLY ON A "PAIN MANAGEMENT" PROGRAM? WHO IS YOUR DOCTOR? _____	☐	☐
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	☐	☐
16. ARE YOU TAKING BLOOD THINNERS?	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	Y	N
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
*PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVE OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE LIST)	☐	☐
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK OR ANGINA	☐	☐
CHEST PAIN	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
PACEMAKER	☐	☐
* HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐

	Y	N
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT DATE: _____	☐	☐
STOMACH ULCER	☐	☐
TUBERCULOSIS	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORE/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
KIDNEY DISEASE	☐	☐

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ON THE REVERSE SIDE OF THIS PAGE? ☐ **YES** ☐ **NO**

PLEASE DESCRIBE IN DETAIL _____

DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY DENTAL PROBLEM ☐ **YES** ☐ **NO**

EMERGENCY CONTACT INFORMATION: NAME _____ TELEPHONE NO _____

INFORMED CONSENT

This is my consent to the endodontic procedures indicated and any other procedures necessary or advisable as a corollary to the planned endodontic therapy performed. I agree to the use of local anesthesia, sedation and/or analgesia, depending on the judgment of the endodontist. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the upper lip, gum or tongue, which rarely is permanent.

I understand root canal therapy is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

I ALSO UNDERSTAND THAT THE ROOT CANAL THERAPY IS TO BE PERFORMED AT THIS OFFICE. THE PERMANENT (OUTSIDE) RESTORATION (FILLING, INLAY, CROWN, ETC.) WILL BE PERFORMED BY MY GENERAL DENTIST.

I understand that medications for pain and sedation may cause drowsiness which may be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call a doctor immediately. I understand that it is my responsiblity to report any changes in my medical history.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL OR BEFORE COMPLETION, UNLESS SPECIFIC ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER IN ADVANCE.

ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

SIGNATURE _____ DATE _____

REVIEWED BY _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I understand that insurance is filed as a courtesy to me and is not a guarantee of payment. I also understand that it is not the policy of this office to enter into any dispute between myself and my insurance company. If my insurance company has not paid within 60 days, I will be billed and any balance remaining on my account will be my responsiblity.

SIGNED (PATIENT OR PARENT IF PATIENT IS A MINOR) _____
DATE _____

I HEREBY AUTHORIZE INSURANCE PAYMENT DIRECTLY TO: Timothy H. Mihle, D.D.S.

SIGNED (INSURED PERSON) _____ DATE _____

AS A COURTESY WE WILL SUBMIT INSURANCE CLAIMS FOR SERVICES RENDERED. ALL PAYMENTS/CO-PAYS ARE DUE AT THE TIME OF TREATMENT.

ACCEPTED FORMS OF PAYMENT:
CASH, MASTERCARD, VISA, DISCOVER & CARE CREDIT.