GLEN E. MUELLER, DMD, MAGD
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PATIENT INFORMATION

Name _____ Preferred Name _____
Home Phone _____ Cell Phone _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Birthdate _____ Social Security Number _____ e-mail address _____
Spouse or Parent's Name _____ Social Security Number _____
Check appropriate box: ( ) Minor ( )Single ( ) Married ( )Widowed ( )Divorced ( )Separated
Person to contact in case of emergency _____ Phone _____
Has any member of your family been treated in our office? _____ Who? _____
Who may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to patient _____
Address _____ Home Phone _____ Cell Phone _____
Social Security Number _____ Birthdate _____
Employer _____ Work Phone _____
Currently a patient in our office? ( )Yes ( )No

PRIMARY DENTAL INSURANCE

Name of insured _____ Relation to patient _____
Birthdate _____ Date of coverage _____ Insurance ID # _____
Employer _____ Work Phone _____
Employer address _____ City _____ State ____ Zip _____
Insurance company _____ Group Number _____
Address _____ City _____ State _____ Zip _____
What is your deductible? _____ Annual Max? _____ How much have you used? _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ( )Yes ( )No
Name of insured _____ Relation to patient _____
Birthdate _____ Date employed _____ Insurance ID # _____
Employer _____ Work Phone _____
Employer address _____ City _____ State _____ Zip _____
Insurance company _____ Group Number _____
Address _____ City _____ State _____ Zip _____
What is your deductible? _____ Annual Max? _____ How much have you used? _____

PLEASE COMPLETE BOTH SIDES

DENTAL HISTORY

Reason for today's visit _____ Former Dentist _____
Date of last dental visit _____ Reason for visit _____ Date of last dental x-rays _____
Check if you have any of the following:

( )Bad breath	( )Grinding teeth	( )Sensitivity to heat
( )Bleeding gums	( )Loose teeth or broken fillings	( ) Sensitivity to sweets
( )Periodontal treatment	( )Sensitivity to biting	( ) Clicking or popping jaw
( )Sensitivity to cold	( ) Food collection between teeth	( )Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____
Has fear of discomfort kept you from regular dental care? _____
Have you had unusual effects from previous dental treatment? Describe. _____
What would you like to change about your smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, Pondimin, and Redux. ( )Yes ( )No
Have you had any serious illnesses or operations? ( )Yes ( )No If yes, describe _____
Have you ever had a blood transfusion? ( )Yes ( )No If yes, give approximate dates _____
(Women) Are you pregnant? ( )Yes ( )No Nursing? ( )Yes ( )No Taking birth control pills? ( )Yes ( )No

Check if you have had any of the following:

( )Anemia	( )Cortisone treatments	( )Hepatitis	( )Scarlet fever
( )Arthritis/Rheumatism	( )Persistent cough	( )High blood pressure	( )Shortness of breath
(Artificial joints	( )Cough up blood	( )HIV/AIDS	( )Skin rash
( )Asthma	( )Diabetes	( )Jaw Pain	( )Stroke
( )Back problems	( )Fainting	( )Liver disease	( )Thyroid problems
( )Blood disease	( )Glaucoma	( )Mitral valve prolapse	( )Tobacco habit
( )Cancer	( )Headaches	( )Pacemaker	( )Tonsilitis
( )Chemical dependency	( )Heart murmur	( )Radiation therapy	( )Tuberculosis
( )Chemotherapy	( )Heart problems	( )Respiratory disease	( )Ulcer
( )Circulatory problems	( )Hemophilia	( )Rheumatic fever	( )Venereal disease

Any other medical conditions not listed? _____
List any medications you are currently taking: Allergies:
_____ _____
_____ _____
_____ _____

AUTHORIZATION & RELEASE

Please read and sign.

I have read and answered the above questions to the best of my knowledge.
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____
Signature of patient or parent if minor Date

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