Miller Dental Group New Patient Information

Name Last: First: MI: Preferred Name:
Address: City: State: Zip:
Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )
Email Address:
Occupation: Sex: F ☐ M ☐ DOB: SSN:
If you are completing this form for another person, what is your relationship to that person? Your Name: Relationship:
In case of emergency, contact: Name: Relationship: Phone: ( )
Primary Insurance Information: Subscriber Name: DOB: SSN:
Insurance Company: Group #: Phone: ( )
Secondary Insurance Information: Subscriber Name: DOB: SSN:
I, the undersigned certify that I (or my dependent have insurance coverage with _____ and assign directly to Miller Dental Group 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. I authorize the use of this signature on all insurance submissions. _____ Signature: Date:

If the patient is a minor, the legal guardian must accompany the patient to all cleaning and restorative appointments

Who may we thank for referring you to our practice? _____

Dental Information: please mark (x) on your response as prompted for the following questions

	Y	N	DK		Y	N	DK
Do your gums bleed when you brush or floss				Do you have earaches or neck pains?			
Are your teeth sensitive to cold, hot, sweet or pressure?				Do you have any clicking, popping or discomfort of the jaw?			
Does food or floss catch between your teeth?				Do you brux or grind your teeth?			
Have you had any periodontal (gum) treatment?				Do you have sores or ulcers in your mouth?			
Have you ever had orthodontic treatment?				Do you wear dentures or partials?			
Have you ever had any problems associated with previous dental treatment?				Have you ever had serious injury to your head or mouth?			
Is your home water supply fluoridated?				Do you participate in active recreational activities?			
Do you drink bottled or filtered water? If yes, how often? Daily-Weekly-Occasionally				Are you currently experiencing dental pain or discomfort?			
What is the reason for your visit today?							
How do you feel about your smile?							
Date of your last dental exam:							
What was done at that time?							
Date of last dental x-rays							

Medical Information: Please mark (x) on your response to indicate if the following pertains to you

	Y	N			
Are you now under the care of a physician?			Physician Name: Phone: ( )		
Are you in good health?			Date of last physical exam?		
Has there been any change in your general health within the last year?	Y	N	Have you had a serious illness, operation or been hospitalized within the past 5 years?	Y	N
If yes, what was the illness or condition being treated?					
Are you taking or have you recently taken any prescription or over the counter medicine(s)?				Y	N

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements?

_____
_____
_____
_____
_____
_____
_____

Medical Information: Please mark (x) on your response to indicate if the following pertains to you

Joint Replacement: Have you had an orthopedic total joint replacement? Date: _____ If yes, have you had any complications?	Y	N	Do you drink alcoholic beverages? If yes, how much did you drink in the last 24 hours _____ If yes, how much do you typically have in a week _____	Y	N
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? Circle one VERY/SOMEWHAT/NOT INTERSTED			**WOMEN ONLY** Are You: Pregnant? Due Date: _____ Taking Birth Control or hormonal replacement Nursing?		
Allergies: Are you allergic to or have you had a reaction to: Local Anesthetics			Metals		
Aspirin			Latex (rubber)		
Penicillin			Iodine		
Amoxicillin			Hay Fever/Seasonal		
Barbiturates, sedatives or sleeping pills			Foods		
Sulfa Drugs			Tylenol		
Codeine			Vicodin		

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems

	Y	N	DK		Y	N	DK
Artificial (prosthetic) heart valve				Previous infective endocarditis			
Damaged valves in transplanted heart				Congenital Heart Disease			
Cardiovascular Disease				Angina			
Arteriosclerosis				Congestive Heart Failure			
Damaged Heart Valves				Heart Attack			
Heart Murmur				Low Blood Pressure			
High Blood Pressure				Other Congenital Heart Defects			
Mitral Valve Prolaps				Pacemaker			
Rheumatic Fever				Rheumatic Heart Disease			
Abnormal Bleeding				Blood Transfusion If yes, Date: _____			
Hemophilia				Aids or HIV infection			
Arthritis/Rheumatism				Autoimmune Disease			
Asthma				Bronchitis			
Emphysema				Sinus Problems			
Tuberculosis				Cancer/Chemotherapy/Radiation Treatment			
Chest pain upon exertion				Eating Disorder/Malnutrition			
Gastrointestinal Disease				G.E. Reflux/persistent heartburn			
Ulcers				Growths/Tumors			
Thyroid Problems				Stroke			
Glaucoma				Hepatitis Type _____, Jaundice, Liver Disease			
Recurrent Infections Type of infection: _____				Neurological Disorders Specify: _____			
Kidney Problems				Epilepsy/Seizures			
Osteoporosis				Persistent swollen glands in neck			
Severe Headaches/Migraines				Severe or rapid weight loss			
Sexually transmitted disease				Excessive Urination			
Diabetes				Other			

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? _____

Name of physician or dentist making recommendation: _____ Phone _____

Do you have any disease, condition, or problem not listed above you think I should know about? If yes, please list below:

_____

_____

Have you traveled outside the country in the last 6 months? If yes where: _____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member or his/her staff, responsible for any action they take or do not take because or errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian Date

Miller Dental Group

Photo Release Consent Form

_____ I give the Miller Dental Group permission to use "Before and After" photos of my cosmetic procedure(s) for the following purposes:

1. Internet/Website smile galleries
2. Photographs to be used in advertisements
3. Display in office smile gallery albums.

_____ I give the Miller Dental Group permission to use only pictures of my smile and/or teeth, while my name and full face characteristics will be kept confidential.

_____ I do **not** give the Miller Dental Group permission to use any of My "Before and After" photos for a smile gallery.

Consent for Release of Information

This Authorization grants permission to my Spouse/Significant Other/Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; be made aware of my diagnosis, prognosis; and have access to my financial health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named below, the released information may no longer be protected by federal privacy regulations.

PATIENT NAME: _____ **DOB:** _____

Authorized Name/Address: _____

Relationship to Patient: _____ **Phone:** _____

Insurance Disclaimer

1. Our practice is one of patient centered care, not insurance directed care. It is most important to us that we correctly diagnose and recommend the most appropriate treatment at the highest standard to care of each of our patients. We coordinate the proposed treatment plan to whatever insurance benefits may be available. While we completely recognize that dental insurance benefits are an important factor in the delivery of any care provided to our patients with dental insurance, we do not diagnose and provide oral health care based on insurance benefits.
2. We attempt to try to estimate what benefits may be available to better predict the out of pocket expense that may be expected after dental insurance benefits. Our estimates are not meant to be exact and cannot be interpreted as absolutes.
3. Information regarding changes to a patients dental benefits must be provided before treatment and it is the responsibility of the patient to update Miller Dental Group as applicable.

_____

Signature of Patient/Legal Guardian Date

Patient Financial Policy

Thank you for choosing Miller Dental Group. Our mission is to deliver the best and most comprehensive dental care available. An essential part of the mission is to make the cost of optimal care as manageable for our patients by offering several payment options.

Payment Options:

You can choose from:

-Cash, Major Credit Card, Debit Card

-Convenient Monthly Payments from CareCredit

Allow you to pay over time with no annual fees or prepayment penalties*

Please note:

Miller Dental Group requires payment at the time services are rendered. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, we extend this as a courtesy and cannot guarantee payment or coverage by your insurance company. If payment is not received from your insurance carrier within 90 days, you will be responsible balances.

Fees quoted for treatment will remain in effect for 6 months and thereafter are subject to change without notice.

A service fee of 1.5% per month (18% annually) on unpaid balances will be charged on all accounts exceeding 60 days.

Accounts more than 90 days past due may be referred to a collection agency or collection attorney. In such a case you will be responsible for any and all fees and expenses of the collection agency or collection attorney relating to the collection of the unpaid amount.

Missed Appointment Policy

Miller Dental Group will implement a ***$100 missed appointment fee*** for any appointments changed or no-showed without 24 hours notice. If you miss your reserved time, this fee must be paid prior to reserving any additional dates/times. As a courtesy, our staff will attempt to remind all patients of future appointments; however, you are responsible for any appointments you make with our office.

Late Arrival

When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. *If you arrive more than 20 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.*

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

*Subject to credit approval

Miller Dental Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** You May Refuse to Sign This Acknowledgment *****

I _____, have received a copy of this Office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

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