Gary P. Miller DDS
Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

NAME: _____ DATE: _____
Last First Middle

I LIKE TO BE CALLED: _____ EMAIL ADDRESS: _____
□ Male □ Female □ Single □ Married □ Divorced □ Widowed

ADDRESS: _____
Street Apt# City State Zip

BIRTH DATE: _____ TELEPHONE: _____
MM/DD/YY Home Cell

DRIVERS LICENSE# _____ SOCIAL SECURITY# _____

PLACE OF EMPLOYMENT: _____ WORK # _____

Has any member of your family ever been treated in our office? □ Yes □ No If yes, who?_____

Whom may we thank for referring you to our office? (check all that apply)

□ Newspaper □ I saw your sign □ Yellow Pages □ Magazine □ Direct Mail □ Internet
□ Acquaintance: _____ □ Another Dr.:_____

Insured Information				Responsible/Billing Party Information			
Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other				Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other			
Last	First		MI	Last	First		MI
Street Address	City	ST	Zip	Street Address	City	ST	Zip
Home/Cell Telephone #	Birth Date (MM/DD/YY)			Home Telephone #	Cell Telephone #		
Employer	Dental Insurance Company			Email Address	Birth Date (MM/DD/YY)		
Insured Social Security # or Insured ID# (if different than social)				Drivers License #	Social Security #		
Insurance Mailing Address				Employer	Work Telephone #		
Ins Phone Number	Group/Plan Number						

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____Telephone Number: _____

May we leave messages announcing our office name in regards to appointments, treatment, and/or insurance/financials on your voicemail? □YES □NO □YES, with exceptions:_____

Please continue to the next page...

Gary P. Miller DDS
Medical History

When was the last time you had dental x-rays taken? _____
Have you ever had a major operation? □Yes □ No Describe: _____
Have you ever had a head or neck injury? □Yes □ No Describe: _____

Are you taking any medication now? □Yes □ No Please list (use back of this form if needed):

_____

Are you allergic to any of the following:

Aspirin □ No □ Yes	Acrylic □ No □ Yes	Penicillin □ No □ Yes
Latex Rubber □ No □ Yes	Codeine □ No □ Yes	Other:_____

Do you have any of the following:

Artificial Limb	□No □Yes	Heart Trouble	□No □Yes	Glaucoma	□No □Yes
Irregular Heart Beat	□No □Yes	Convulsions	□No □Yes	Renal Dialysis	□No □Yes
Mitral Valve Prolapse	□No □Yes	Scarlet Fever	□No □Yes	Rheumatic Fever	□No □Yes
High Blood Pressure	□No □Yes	Blood Disease	□No □Yes	Venereal Disease	□No □Yes
Low Blood Pressure	□No □Yes	Hepatitis A B C	□No □Yes	Anemia	□No □Yes
Excessive Bleeding	□No □Yes	Stroke	□No □Yes	Sickle Cell	□No □Yes
Hemophilia	□No □Yes	Rx Diet Pills	□No □Yes	Leukemia	□No □Yes
Recent Transfusion	□No □Yes	Cold Sores	□No □Yes	Swelling of limbs	□No □Yes
Tuberculosis (TB)	□No □Yes	Drug Addiction	□No □Yes	Cancer	□No □Yes
Breathing Problems	□No □Yes	HIV Positive	□No □Yes	Radiation Therapy	□No □Yes
Chemotherapy	□No □Yes	Genital Herpes	□No □Yes	Ulcers	□No □Yes
Digestive Problems	□No □Yes	Diabetes	□No □Yes	Hypoglycemia	□No □Yes
Recent Weight Loss	□No □Yes	Kidney Problems	□No □Yes	AIDS	□No □Yes

Have you ever had any serious illness not checked above? If yes, describe:

Important!!! For Women Only
Are you pregnant? □ No □ Yes
Are you trying to get pregnant? □ No □ Yes
Are you nursing? □ No □ Yes
Are you taking oral contraceptives? □ No □Yes

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

X_____
Signature of □ Patient or □ Guardian Date

I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This 'signature on file' will be valid from this date. A photocopy of this document may act as an original.

X_____
'Signature on file' of □ Patient or □ Guardian Date

Gary P. Miller DDS
Financial and Insurance Policy

Our primary responsibility to you is to provide quality dental care. To maintain this standard of care, we believe that it is in the best interest of everyone to establish a patient account policy up front to avoid any misunderstandings. We will provide you with a written estimate of your financial investment prior to any treatment being rendered. Treatment estimates quoted are good for 90 days from the date of the estimate.

1. **PAYMENT IS EXPECTED ON THE DATE OF SERVICE**…In some instances, we may ask that you prepay for your dental services to reserve special appointment dates and/or times. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

□ Credit Card □ Cash □ Check □ Care Credit □ I would like to know more about my financial options

2. **DENTAL INSURANCE**…We want to help you maximize your insurance benefits. Please remember, dental insurance does not always cover the cost of your treatment as anticipated. While dental/medical costs have increased exponentially in the past 10 years, dental insurance benefits have remained relatively unchanged over the past 40 years. We do not allow insurance companies to dictate the course of treatment for our patients. Rest assured that we will recommend a treatment plan that is appropriate for your diagnosis regardless of what your insurance might or might not reimburse.

We are more than happy to request that your insurance benefits be sent directly to our office with your consent and if your plan offers this service. Unfortunately, there are a few instances in which we cannot accept assignment of benefit. Some carriers will not send payment to the provider, even when we request that they do so. There are also insurance plans that are set up to reimburse on a "fee schedule", rendering estimates of coverage impossible. Finally, COBRA insurance, which is month to month insurance, pays benefits totally dependent upon receiving a premium by a set date. In these three instances, we ask that you pay in full for services at which time we will handle the paperwork to see that you receive direct reimbursement from your carrier in a prompt manner.

Many insurance plans have frequency limitations, alternate benefit clauses, and other exclusions that ***may limit your coverage***. Ultimately, the patient is financially responsible for treatment costs. As a courtesy, we will attempt to obtain an *estimate* of your dental insurance assistance prior to services being rendered. If insurance does not pay as anticipated, our financial policy requires that the remaining balance be paid in full within 25 days of the final billing date. In addition, any insurance claim aged over 60 days that has not been paid or denied by the insurance carrier will become the patient's responsibility.

3. **ADDITIONAL ACCOUNT CHARGES**…We reserve the right to add a service charge to overdue accounts. The service charge will be a minimum of $5.00 and a maximum of $25.00 each month. A charge of $25 will be applied to all returned checks. We require that returned checks and fees be cleared by cash, certified funds, or credit card. We also reserve the right to charge up to **$50 per lost hour for last minute cancellations and failed appointments.**

4. **DIVORCED PARENTS and THIRD PARTY BILLING**…It is the policy of this office that the parent/guardian accompanying the child to the visit be held responsible for treatment consents and all charges incurred; regardless of insurance, divorce decrees, or financial situations. We do not bill to any other third parties and we do not accept assignment of benefits from secondary insurance.

By signing below, I acknowledge that I understand and agree to Gary P. Miller DDS's financial policies. Even if I do not currently have dental insurance, I understand that the "Dental Insurance" section applies to me should I obtain dental insurance in the future. I will promptly notify the business office with any changes in my phone numbers, mailing address, and dental insurance coverage and/or eligibility status. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

X_____

Signature of □ Patient or □ Parent/Guardian Date

Gary P. Miller DDS
PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

PREVENTATIVE CARE: I consent to services provided for regular diagnostic and routine care recommended by Gary P. Miller DDS. These services may include but are not limited to prophylaxis (cleaning), oral examination performed by a dentist, periodontal evaluation, oral cancer screening, and fluoride treatment. I understand that the long term success of treatment and status of my oral condition depends on my efforts at maintaining proper oral hygiene (i.e. brushing and flossing) and my diligence with regular recall visits. I further understand that failure to abide by recall intervals set by Gary P. Miller DDS will negate any guarantee that may exist on restorative and/or prosthetic services provided by the dentists. _____ (Initials)

DIAGNOSTIC RADIOGRAPHS: I understand that Gary P. Miller DDS utilizes intra-oral and extra-oral digital radiograph to assist in obtaining an accurate diagnosis of dental condition(s). I authorize the performance of x-rays that the dentist considers necessary or advisable in the course of my examinations. _____ (Initials)

NITROUS OXIDE – I understand that to reduce anxiety, nitrous oxide is available to me for a small fee. Nitrous oxide is a mild gas that is mixed with oxygen and is used to sedate a person. It is administered through a mask placed over the nose. It can produce sensations of drowsiness, warmth and tingling in the hands, feet and/or about the mouth. In the dental setting, it will not induce unconsciousness. You will be able to swallow, talk and cough as needed. Recovery from nitrous oxide sedation is rapid. The gas will be flushed from your system with oxygen and you will be able to walk and drive safely. _____ (Initials)

LOCAL ANESTHETIC: I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that I may inadvertently bite my lip causing possible injury. I understand the need to return to the office, for evaluation, if swelling and/or pain does not go away after a sufficient period of time. _____ (Initials)

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT ANY PROPOSED DIAGNOSTIC, PREVENTATIVE, AND/OR PERIODONTAL TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS. **_____ (Initial)**

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS CONSENT, AND AGREE TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION. **_____ (Initial)**

I UNDERSTAND THAT THIS FACILITY PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS. _____ **(Initial)**

I HAVE BEEN OFFERED AND/OR HAVE BEEN GIVEN A COPY OF THIS OFFICES PRIVACY PRACTICES FOR THE PROTECTION OF MY PERSONAL INFORMATION IN ACCORDANCE WITH GOVERNMENT HIPAA REGULATIONS. **_____ (Initial)**

Signature:_____ **Date:**_____

Relationship to Patient:_____

Gary P. Miller DDS
HIPAA RELEASE FORM

I,_____, authorize the release of information on
(PRINT PATIENT / GUARDIAN NAME)

_____, including the diagnosis, records, examination and
(PRINT PATIENT NAME)
treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone. (Initial Here)_____

In further consideration for this, Gary P. Miller DDS agrees to the same stipulations.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other_____

The best phone number to reach me at is:_____

Signed: _____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____