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
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: _____/_____/_____

The Financial Policy of
Dr. Gary P. Miller

Thank you for choosing our office as your dental health care provider. Our primary responsibility is providing the highest quality dental care for you and your dependents. Part of our commitment is your understanding and responsibility for the payment of your account balance.

Our basic financial policy is the following:

FULL PAYMENT OR PATIENT ESTIMATE IS DUE AT THE TIME OF SERVICE. PAYMENT ARRANGEMENTS CAN BE MADE IF EXTENSIVE TREATMENT IS PLANNED AND APPROVED BY OUR OFFICE MANAGER.

WE ACCEPT CASH, CHECK, DEBT CARDS, MAJOR CREDIT CARDS AND THIRD PARTY FINANCING THROUGH CARE CREDIT. WE CAN OFFER IN OFFICE PAYMENT PLANS BUT THEY MUST BE APPROVED PRIOR TO TREATMENT. A PAYMENT PLAN AGREEMENT WILL BE SIGNED.

ALL PATIENTS

Patients are responsible for full payment or patient estimate at the time of service unless specific arrangements are made prior to the start of treatment.

REGARDING INSURANCE

Full payment is invoiced at time of service. We are currently a participating provider with the following insurance companies: Delta Dental, Humana, BCBS of TX, United Healthcare, Dental Select, United Concordia, Lincoln, GEHA, Sunlife, Careington, & Cigna. All other dental PPO insurance plans are accepted on an out-of-network basis. We will accept assignment of participating insurance plans and will submit dental claims on our patient's behalf. We are not able bill for insurance benefits only. A pre-treatment estimate will need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered.

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Any insurance claim not settled within 45 days will be due in full. It's your responsibility to pay our practice in full for the treatment invoice.

Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled too.

PATIENT RESPONSIBLTY AND ADDITIONAL TERMS

Accounts unpaid after 60 days from day of service are subject to a delinquent fee of $35.00. Furthermore, the unpaid balance is subject to a 1.5% monthly (18% Annual) finance charge. If we have to submit your unpaid account to a collection process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees.

MISSED OR LATE APPOINTMENTS/RETURNED CHECKS

Unless appointments are cancelled at least **24 hours** in advanced, our policy is to charge for missed appointments. You will be charged a $75.00 **non-refundable** fee for treatment appointment and $50.00 **non-refundable** fee for hygiene appointment. Any returned check will carry a $50.00 fee.

1) As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us 24 hours in advance to change or cancel the reserved time. **PLEASE CONFIRM YOUR APPOINTMENT EVEN IF YOU PLAN ON BEING HERE.**

2) If missed appointments become repeated, any future appointments will require a credit card number to be kept on file and used immediately for a missed appointment fee.

3) If you are more than 15 minutes late, we will not be able to see you and it will be considered a missed appointment and you will be charged accordingly.

Our entire staff is dedicated to you, the patient. Please let us know if you have any questions or concerns.

I have read this ***Financial Policy***. I understand and agree to the terms of the ***Financial Policy of Dr. Gary P Miller.***

X _____ Date_____
Signature of Patient or Parent of Minor Patient

X_____ Date_____
Signature of Co-Responsible Party