Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out these forms completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name_____ Birth Date_____ Soc. Sec. #_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ E-Mail_____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Other ☐Male ☐Female

If Student, Name of School_____ City_____ State_____ Full or Part Time_____

Patient or Parent's Employer_____ City_____ State_____ Work Phone_____

Business Address_____ City_____ State_____ Zip Code_____

Spouse or Parent's Name _____ Work or Cell Phone _____

Person to Contact in Case of Emergency_____ Phone_____

Whom May We Thank for Referring You? _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Driver's License #_____ Birth Date_____ Financial Institution_____

Employer_____ Work Phone _____ Soc. Sec. #_____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the method you prefer. Payment is due in full at each appointment.

☐Cash ☐Personal Check ☐Visa ☐Master Card ☐Discover ☐Care Credit

If Insured, Please List the Name(s) of your Dental Insurance(s)_____

Financial Policy

YOUR INSURANCE is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on a contract. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid by your insurance. We will assist you in filing your insurance as much as possible, but you are responsible for your bill if your insurance has not responded in 60 days. **DELINQUENT ACCOUNTS** will be referred for collections after 30 days and subject to credit reporting. You will also be responsible for the additional collection fees/attorney fees accrued as a result. **APPOINTMENT CANCELATIONS**: We request at least 24 hours notice if you need to cancel an appointment. There will be a $25.00 fee for every 30 minutes scheduled that is canceled with less than 24 hours notice or no notice at all, except in the case of an emergency.

I have read and understand the Financial Policy of this dental office and agree to comply

_____ _____

Signature Date

Patient Medical History

Medical Physician_____ Office Phone_____ Last Exam_____

1. Do you have or have you had any of the following?

	YES	NO
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Pericarditis	☐	☐
Fainting/Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy/Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐

	YES	NO
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis/Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles/Ulcers	☐	☐

	YES	NO
Chest Pains	☐	☐
Easily Winded	☐	☐
Stroke	☐	☐
Hay Fever/Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐
Other_____	☐	☐

	YES	NO
2. Are you under medical treatment now?	☐	☐
3. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain:_____		
4. Are you taking any medications, including non-prescription medicine?	☐	☐
If yes, what medications are you taking?_____		
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you or have you taken medication for Osteoporosis/Bone loss	☐	☐

8. Are you allergic to or have you had any reactions to any of the following?	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____	☐	☐
9. Women Only:		
a) Are you pregnant or think you might be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam_____

	YES	NO
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐
Are your teeth sensitive to sweet or sour liquids/food?	☐	☐
Do you feel constant pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐

	YES	NO
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement_____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X_____

Signature of Patient (or Parent if patient is a minor)

Edward B. Miller, D.D.S. & Associates
410 W. Wheatland Rd.
Duncanville, Tx. 75116
972-298-6131

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, **Edward B. Miller, D.D.S. & Associates** may use and disclose protected health information **(PHI)** about me to carry out treatment, payment and healthcare operations **(TPO)**. Please refer to **Edward B. Miller, D.D.S. & Associates** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Edward B. Miller, D.D.S. & Associates** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained in the front office.

With my consent, **Edward B. Miller, D.D.S. & Associates** may contact my **(Please circle all that applies)**

Home Answering Machine/Voicemail Cell Phone Business Phone Email

With my consent, **Edward B. Miller, D.D.S. & Associates** may speak with my **(Please circle all that applies)**
Spouse Children Guardian Other (specify) _____

and leave a message in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others, or may speak to the people circled above in person about my care.

With my consent, **Edward B. Miller, D.D.S. & Associates** may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, **Edward B. Miller, D.D.S. & Associates** may call a Pharmacy, which I have chosen, to leave prescription information, such as a patient name and/or date of birth, with the pharmacist and/or staff, pharmacy voicemail and/or fax

By signing this form, I am consenting to **Edward B. Miller, D.D.S. & Associates** use and disclosure of **PHI** to carry out **TPO.**

I may revoke my consent in writing except to the extent that the practice has already made the disclosure in reliance upon my prior consent. **IF I DO NOT SIGN THIS CONSENT, Edward B. Miller, D.D.S. & Associates MAY DECLINE TO PROVIDE TREATMENT TO ME.**

_____ _____

Signature of Patient or Legal Guardian Date