

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

Cell Phone _____ Email _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment: _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) yes or no whether you have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet fever | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | | |

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist 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 the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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

Paul R. Miller, DDS

7711 Quarterfield Road, Suite C-1 ♦ Glen Burnie, MD 21061 ♦ (410)760-4445

PATIENT FINANCIAL POLICY

Our office strives to provide the highest quality dental care at affordable prices. Our patients receive prompt attention and excellent service. We believe that a satisfied patient returns for additional services, refers others to the practice and pays their bill promptly. To help maintain a good relationship with our patients, this office has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefits. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. Ultimately, you are responsible for the entire cost of your dental therapies. Any questions or comments regarding your benefits should be directed to your insurance carrier.

1. Payment at the time of service is expected, including the estimated portion of the amount that insurance does not cover. Our office accepts the following payment methods: Cash, Check, MasterCard, VISA, AmEx, and Discover.
2. When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 90 days, an interest rate of 18% per annum will be charged on all outstanding balances.
3. A credit report will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements. Payment history with our office will be taken into consideration when establishing payment arrangements.
4. Interest of 18% per annum will be assessed on the patient's portion of the unpaid balance as noted above (#2). A written, signed agreement will be completed at our office, which explains the number of payments, interest rate and total interest to be paid over the term of the agreement.
5. A statement for services rendered will be mailed to you at the end of each month. Receipt of payment is expected by the 10th of the month. The patient's payment should be mailed with the top portion of the statement to establish the proper crediting of the account.
6. Your account due is considered delinquent if the requested payment is not received by the tenth (10th) of the month. If payment is not received, a late charge of 1 ½% per month (\$1.00 minimum) will be assessed and will appear on the next statement. The annual percentage rate is 18%.
7. A \$35.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.
8. There will be no charge for a broken appointment with 24 hours' notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. Broken appointments with less than 24 hours' notice will incur a \$50.00 fee.
9. Delinquent accounts may be sent to a collection agency.
 Yes, I am interested in payment arrangements that may be made available to me in order to complete my dental treatment.

I have read and understand the financial policy of Dr. Miller and agree to all the terms described in it.

Patient Signature/Guardian Signature

Date

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

Paul R. Miller, DDS
7711 Quarterfield Rd. Suite C-1
Glen Burnie, MD 21061
410-760-4443

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other



Paul R. Miller, D.D.S.

Exceptional dentistry for the quality conscious.

COSMETIC / ESTHETIC EVALUATION

Are you delighted with your smile? _____

Please rate your smile from 1 to 10 (1 being terrible, 10 being awesome) _____

Would you like to have whiter teeth? _____

If you had a magic wand, what, if anything, would you change about your smile? _____

What personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Are you interested in oral sedation to complete your dentistry in one visit? _____

Through state of the art technology in cosmetic dentistry, we have the ability to help you achieve a World Class Smile, often overnight.

Using our computer assisted dental imaging, and high-resolution video photography, we can simulate how you would look after the improvements. Imaging will be performed as part of your exam.

Would you like to see what you could look like with a new and improved smile? _____

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Lighten all front teeth | <input type="checkbox"/> Rebuild Fractures | <input type="checkbox"/> Straighten rotation |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Close spaces | <input type="checkbox"/> Lengthen teeth |
| <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Repair uneven edges | <input type="checkbox"/> Shorten teeth |
| <input type="checkbox"/> Eliminate dark fillings | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Reduce gum showing in smile |

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Patients Name: _____

Date: _____

YES

NO

1. Do you have Sleep Apnea?

2. Do you snore loudly?

(Louder than talking or loud enough
to be heard through closed doors)

3. Do you often feel tired, fatigued,
or sleepy during the daytime?

4. Has anyone observed you stop
breathing during your sleep ?

5. Do you have or are you being
treated for high blood pressure ?
