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 any questions we'll be glad to help you. We look forward to working with you in maintaining your oral health.

PATIENT INFORMATION

Date_____ Patient's Name_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐Divorced ☐Widowed

If married, Spouse name_____ Home#_____ Cell#_____

Soc. Sec. #_____ Birthdate_____ Email_____

Whom may we thank for referring you? ☐Yellow Pages ☐Google ☐DexKnows ☐Walk in/Drive by ☐Insurance ☐Radio ☐ Referred By: _____ ☐Other: _____

In case of emergency who should be notified? _____ Phone(___)_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Are you currently under physicians care? ☐ Yes ☐ No If yes, why _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

Check (✓) if you have or have had any of the following:

☐ Anemia
☐ Anxiety
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Emphysema
☐ Diabetes
☐ Epilepsy/Seizures
☐ Fainting
☐ Glaucoma
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High/Low Blood Pressure
☐ HIV/AIDS/ARC
☐ Jaw Pain TMJ/TMD
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

Have you had any serious illnesses or operations not checked above? ☐ Yes ☐ No If yes, describe _____

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy ☐ Yes ☐ No

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____ Phone (___)_____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you brush? _____ How often do you floss? _____

Do you use any Tobacco products? Yes ☐ No ☐ If Yes, what product(s) and how often? _____

TREATMENT AUTHORIZATION

The information on this page is correct to the best of my knowledge. I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Patient or Parent/Guardian Print Name:_____ Date _____

Patient or Parent/Guardian Signature:_____

ACCOUNT INFORMATION

Parent/Guardian Information _____

Last Name First Name Middle

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

Employed by_____ Employer Phone (___)_____

☐Single ☐Married ☐Divorced ☐Widowed

Primary Dental Insurance Information

Policy Holder Name_____ Birthdate_____Soc.Sec#_____

Employed by_____ Employer Phone (___)_____

Insurance Company_____Group #_____Insurance Phone (___)_____

Is patient covered by additional dental insurance? ☐ Yes ☐ No

If yes, please complete the following secondary insurance information.

Insured's Name _____ Relation to Patient _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____

Insurance Company_____ Group #_____

OFFICE FINANCIAL POLICY

Payment is expected at the time of service unless prior arrangements have been made. We will accept cash, check, credit card, automatic monthly billing to your Visa, MasterCard, American Express or Care-Credit. Please see front office staff to set up payment arrangements (if necessary).

I agree to pay a finance charge of 1.5% per month (18% per annum) on all unpaid balances commencing 30 days from the service date. In addition, I agree to pay any additional charges related to the cost of collection including reasonable attorney's fees and any collection agency fees which may equal 50% of any unpaid amount due in the event that I would fail to pay my bills.

I authorize my insurance company to pay 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.

**We will file pre-treatment estimates, at your request only.

Print Name_____ Sign Name_____ Date_____

MISSED APPOINTMENT POLICY

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we enforce a missed appointment policy to ensure that other patients receive care in a timely manner. Missed appointments and appointments cancelled without 24-hour notice are subject to a cancellation fee of $35.

Print Name_____ Sign Name_____ Date_____

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on this date _____ / _____ / _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force. In addition, I consent and allow the persons listed below to obtain my records upon request.

I allow my records to be released to (list all): _____

Print Name_____ Sign Name_____ Date_____

RECEIVE APPOINTMENT REMINDERS VIA EMAIL AND TEXT

PLEASE CHECK A SOURCE IN WHICH YOU WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS

- ☐ Email
- ☐ Text Message
- ☐ Both Email and Text Message

Email Address: _____

(*if applicable)*

Cell Phone: _____

(*if applicable)* **MUST REPLY WITH "Y" WHEN PROMPTED**

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Milner Dentistry in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Milner Dentistry in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send and e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

Print Name_____

Signature_____ Date_____

SMILE EVALUATION

Your smile affects your self-image, and can greatly influence the quality of your interactions with others. Many people hold back from laughing or smiling because they are uncomfortable with their smile. The following questions are designed to honestly appraise your smile.

Are you dissatisfied with the appearance of your smile?	☐Yes ☐No
Are any of your teeth yellow, stained or somewhat discolored?	☐Yes ☐No
Would you like your teeth to be whiter?	☐Yes ☐No
Do you have spaces or gaps between your teeth?	☐Yes ☐No
Are you missing any teeth?	☐Yes ☐No
Do you have any old fillings or dental work that you don't like looking at?	☐Yes ☐No
Are any of your teeth worn down, chipped, crowded/uneven or misshapen?	☐Yes ☐No
Are your gums red, sore, puffy, bleeding or receded?	☐Yes ☐No
Does the appearance of your smile inhibit you from laughing or smiling?	☐Yes ☐No
When being photographed, do you smile with your lips closed instead of flashing a full smile?	☐Yes ☐No

Please list and/or explain any additional concerns:

_____

_____

_____