

Matthew G. Miller D.D.S., Inc.
PATIENT'S INFORMATION AND HEALTH HISTORY
(PLEASE COMPLETE IN INK)

Patient's Name: _____ DOB: _____

Referred by: _____

Answers to the following questions are for our records only and will be considered confidential.

1. Physician's Name _____ Date of last Physical Examination _____
2. Date of Last Dental Examination(if not here) _____ Dentist's Name (if not here) _____
3. Date of Last Dental X-Rays(if not here) _____ Weight of Patient _____ As of _____
(Date)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Is patient in good health?	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive? ARC? AIDS?
<input type="checkbox"/>	<input type="checkbox"/>	Has patient had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to latex/rubber (gloves, balloons, etc.)?
<input type="checkbox"/>	<input type="checkbox"/>	Is any surgery planned?	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to penicillin or other drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Is patient receiving any medication?(please list)	<input type="checkbox"/>	<input type="checkbox"/>	Soy, egg, peanut, or tree/pine nut allergy?
		Has patient had a history of:	<input type="checkbox"/>	<input type="checkbox"/>	Other food allergy?
<input type="checkbox"/>	<input type="checkbox"/>	Developmental delays? Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis?
<input type="checkbox"/>	<input type="checkbox"/>	Autistic Spectrum?	<input type="checkbox"/>	<input type="checkbox"/>	GI disease? Celiac disease?
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infection? Recently?
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble, i.e. murmurs, defects, surgery, etc.??*	<input type="checkbox"/>	<input type="checkbox"/>	Strep throat? Recently?
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease/trait??
<input type="checkbox"/>	<input type="checkbox"/>	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient take fluoride at home?
<input type="checkbox"/>	<input type="checkbox"/>	Kidney, liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient have sucking habits?
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	Have any cavities been noted in the past?
<input type="checkbox"/>	<input type="checkbox"/>	Tumors or growths?	<input type="checkbox"/>	<input type="checkbox"/>	Have there been any injuries to the teeth, falls, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Serious head injuries?	<input type="checkbox"/>	<input type="checkbox"/>	Any sore areas in the mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	Has patient had any unfavorable dental experiences?
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy? Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Does patient have any breathing difficulties?
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease? Excessive bleeding?			(enlarged adenoids or tonsils, snoring?)
<input type="checkbox"/>	<input type="checkbox"/>	Nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Clenching, grinding teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Artificial prosthesis, organs, joints, implants, shunts, valves?	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems?
<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida?
<input type="checkbox"/>	<input type="checkbox"/>	Cancer therapy? Immunosuppressed?	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant?
			<input type="checkbox"/>	<input type="checkbox"/>	Other? Specify in #5 below

***Please inform our office before the patient's appointment if premedication is required.**

4. Please list all medications the patient is currently taking, (including prescriptions, birth control pills, over the counter medications, vitamins and homeopathic or herbal medications). _____

5. Is there anything related to the patient's medical or dental history that you have not indicated above? If yes, explain: _____

6. Purpose of this dental visit? _____

In our practice, if necessary, we may use radiographs, anesthetics, antibiotics, analgesics, sedatives, and nitrous oxide-oxygen sedation. We will discuss any such treatment with you in advance.

I acknowledge that I am responsible for informing the doctor about any changes in the patient's health history prior to treatment. I understand the patient's health history information will be used as necessary for diagnosis or treatment by the doctors of Matthew G. Miller D.D.S., Inc.. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. **I acknowledge that I am financially responsible for all charges.** If requesting a payment plan, I authorize you to request a credit history report.

SIGNATURE: _____ Date: _____
RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

FOR EXISTING PATIENTS: **PLEASE INITIAL & DATE AFTER YOU HAVE REVIEWED AND UPDATED ALL INFORMATION. PLEASE ALERT OUR STAFF IF YOU HAVE CHANGED OR ADDED INFORMATION**

INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____

INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____ INITIAL: _____ DATE: _____

<p>CHILD</p> <p>1. NAME: _____ NICKNAME: _____</p> <p>2. DATE OF BIRTH: _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p> <p>3. ADDRESS: _____ (If P.O. Box, give street address too) CITY: _____ STATE: _____ ZIP: _____</p> <p>4. PHONE: H _____ C _____ W _____</p>	<p>ARE YOU COVERED BY DENTAL INSURANCE? YES NO</p> <p>Insurance will not be billed unless we are provided with the following information: 1) Dental insurance card – provided? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Relocation orders (for military dependents) 3) All insurance information must be completed and updated at each visit.</p> <p>Note: Dual coverage for children: Primary insurance determined by the parent whose month & day of birth is earliest in the year.</p> <p>Our office bills your insurance as a courtesy to you. The information you provide must be current. It is not always possible to predict which services are covered by a carrier or how much they will pay for a particular service. We do not have contracts with insurance companies.</p>
<p><input type="checkbox"/> FATHER EMAIL _____ <input type="checkbox"/> LEGAL GUARDIAN Relationship to patient _____</p> <p>7. NAME: _____</p> <p>8. DATE OF BIRTH: _____ / _____ / _____</p> <p>9. ADDRESS: _____ (If P.O. Box, give street address too) CITY: _____ STATE: _____ ZIP: _____</p> <p>10. PHONE: H _____ C _____ W _____</p> <p>11. EMPLOYER: _____</p> <p>12. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____</p> <p>13. SOCIAL SECURITY NO: _____ - _____ - _____</p> <p>14. CHECK ONE: MARRIED _____ UNMARRIED _____ SEPARATED _____ WIDOWED _____</p> <p>DOES CHILD RESIDE WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>1ST INSURANCE (PRIME)</p> <p>EMPLOYEE NAME _____ MALE _____ FEMALE _____</p> <p>RELATIONSHIP TO PATIENT _____ SS# _____</p> <p>DATE OF BIRTH _____ INSURANCE ID# _____</p> <p>EMPLOYER NAME _____</p> <p>DENTAL INSURANCE CO. NAME _____ EFFECTIVE DATE _____</p> <p>INSURANCE ADDRESS _____</p> <p>INSURANCE PHONE # _____ INSURANCE GROUP # _____</p>
<p><input type="checkbox"/> MOTHER EMAIL _____ <input type="checkbox"/> LEGAL GUARDIAN Relationship to patient _____</p> <p>7. NAME: _____</p> <p>8. DATE OF BIRTH: _____ / _____ / _____</p> <p>9. ADDRESS: _____ (If P.O. Box, give street address too) CITY: _____ STATE: _____ ZIP: _____</p> <p>10. PHONE: H _____ C _____ W _____</p> <p>11. EMPLOYER: _____</p> <p>12. ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____</p> <p>13. SOCIAL SECURITY NO: _____ - _____ - _____</p> <p>14. CHECK ONE: MARRIED _____ UNMARRIED _____ SEPARATED _____ WIDOWED _____</p> <p>DOES CHILD RESIDE WITH YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>2ND INSURANCE (PRIME)</p> <p>EMPLOYEE NAME _____ MALE _____ FEMALE _____</p> <p>RELATIONSHIP TO PATIENT _____ SS# _____</p> <p>DATE OF BIRTH _____ INSURANCE ID# _____</p> <p>EMPLOYER NAME _____</p> <p>DENTAL INSURANCE CO. NAME _____ EFFECTIVE DATE _____</p> <p>INSURANCE ADDRESS _____</p> <p>INSURANCE PHONE # _____ INSURANCE GROUP # _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>Have you or any member of your family seen this or any other dentist in this building? YES NO If yes, name of other dentist _____</p> <p>Which family members/siblings? _____</p> </div>

MATTHEW MILLER, D.D.S., INC.
FINANCIAL POLICY

Thank you for choosing us to provide your dental care. We are very proud of the fact that our practice is committed to providing quality care and a comfortable dental experience for your child. An important part of the relationship that we establish with our parents is a clear understanding of our policies regarding payment for the care that we provide.

FOR OUR PATIENTS WITH DENTAL INSURANCE:

Our goal is to help you to get maximum benefit from your dental insurance coverage. We will gladly bill your insurance company for you. However, dental insurance coverage can be very unpredictable. We do not always know how much it will pay for dental services. Because of this, any estimate that we give you for the portion of the bill that you will have to pay is only an **estimate** and is subject to change. **We ask that you pay your estimated portion in full at each visit.** We accept cash, check, and credit cards (Visa, MasterCard, Discover Card). Monthly payment plans are also available through Care Credit or Citi Health Card. If, for any reason, your insurance company does not pay in a timely manner for part, or all, of the treatment provided, you are ultimately responsible for any outstanding balance.

Diagnostic x-rays in a pediatric dental office may be needed more frequently than your insurance plan allows. It is important to understand that we provide care based upon what is necessary for your child's dental health, not what is allowed under the coverage provided by your insurance plan.

FOR OUR PATIENTS WITHOUT DENTAL INSURANCE:

We ask that you pay for treatment on the day that it is provided. We accept cash, checks, and credit cards (Visa, MasterCard and Discover Card). Monthly payment plans are also available thru Care Credit or Citi Health Card. Payment at the time of the visit is required whether or not a minor child is accompanied by an adult.

We do require 24 hours notice to cancel any appointment. It is our policy after 2 missed appointments with less than 24 hours notice or two broken appointments; you will be required to pay in advance to secure another appointment. If a third prepaid appointment is missed or cancelled with less than 24 hours notice, your prepayment will not be reimbursed and your child may be dismissed from our practice.

I understand, and agree to follow these financial policies.

Child's Name: _____ Date: _____

Parent's (Guardian's) Signature: _____

Matthew G. Miller, D.D.S., Inc.



Our fax number: 831-241-6359

RELEASE OF TREATMENT/RECORDS FORM

With your written permission, we may discuss your dental information with a person(s) you designate. Your authorization allows dental providers and staff members to discuss your health history, dental treatment, finances and appointments (including scheduling) with a designated adult such as a family member, friend, dental or medical practitioner. This request also includes emailing any dental x-rays via a secured website.

Patient name: _____
 First Middle Last name

This patient is : () Adult (18 years or older) () Minor child () Dependent adult

() YES, I specifically authorize Dr. Matthew G. Miller's office to disclose my information to the following:

- | | |
|----------|-------------------------|
| 1. _____ | _____ |
| Name | Relationship to Patient |
| 2. _____ | _____ |
| Name | Relationship to Patient |
| 3. _____ | _____ |
| Name | Relationship to Patient |
| 4. _____ | _____ |
| Name | Relationship to Patient |
| 5. _____ | _____ |
| Name | Relationship to Patient |

() NO, I do NOT want my information shared with any individuals

This authorization is valid until otherwise revoked.

I may cancel this consent at any time by sending a written notice to Dr. Matthew G. Miller. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

Parent's Signature/Date: _____

MONTEREY



I, _____

have received a copy of the

- a) Notice of Privacy Practices
- b) Dental Materials Fact Sheet

Patient Signature _____ Date _____

Matthew G. Miller, D.D.S., Inc.
333 El Dorado Street Monterey, CA 93940
831-375-4877 * Fax 831-241-6359
mattmillerdds.com
Facebook.com/doctormiller1
Facebook.com/doctormiller2