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	
☐	☐	Is patient in good health?	☐	☐	HIV positive? ARC? AIDS?
☐	☐	Has patient had surgery?	☐	☐	Allergy to latex/rubber (gloves, balloons, etc.)?
☐	☐	Is any surgery planned?	☐	☐	Allergy to penicillin or other drugs?
☐	☐	Is patient receiving any medication?(please list)	☐	☐	Soy, egg, peanut, or tree/pine nut allergy?
		Has patient had a history of:	☐	☐	Other food allergy?
☐	☐	Developmental delays? Syndrome?	☐	☐	Hepatitis?
☐	☐	Autistic Spectrum?	☐	☐	GI disease? Celiac disease?
☐	☐	Diabetes?	☐	☐	Ear Infection? Recently?
☐	☐	Heart trouble, i.e. murmurs, defects, surgery, etc.?*	☐	☐	Strep throat? Recently?
☐	☐	High blood pressure?	☐	☐	Sickle cell disease/trait??
☐	☐	Asthma?	☐	☐	Does patient take fluoride at home?
☐	☐	Kidney, liver disease?	☐	☐	Does patient have sucking habits?
☐	☐	Rheumatic fever?	☐	☐	Have any cavities been noted in the past?
☐	☐	Tumors or growths?	☐	☐	Have there been any injuries to the teeth, falls, etc.?
☐	☐	Serious head injuries?	☐	☐	Any sore areas in the mouth?
☐	☐	Tuberculosis?	☐	☐	Has patient had any unfavorable dental experiences?
☐	☐	Epilepsy? Seizures?	☐	☐	Does patient have any breathing difficulties?
☐	☐	Blood Disease? Excessive bleeding?			(enlarged adenoids or tonsils, snoring?)
☐	☐	Nervous disorders?	☐	☐	Clenching, grinding teeth?
☐	☐	Artificial prosthesis, organs, joints, implants,	☐	☐	Speech problems?
		shunts, valves?	☐	☐	Spina Bifida?
☐	☐	ADHD/ADD	☐	☐	Pregnant?
☐	☐	Cancer therapy? Immunosuppressed?	☐	☐	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? ____

I authorize Matthew Gregory Miller, DDS, Inc to examine my child in order to complete his own diagnosis prior to performing any dental treatment. This can include oral hygiene instruction, prophylaxis, and topical fluoride application. I understand the initial visit may require x-rays to complete a full diagnosis and treatment plan and you will be informed prior to taking any x-rays. I also understand on subsequent visits new x-rays may be required depending on your child's individual caries risk. 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. In our practice, if necessary, we may use radiographs, anesthetics, antibiotics, analgesics, sedatives, nitrous oxide-oxygen sedation, and dental restorative materials. We will discuss any such treatment with you in advance via a detailed treatment plan. **I acknowledge 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:_______

CHILD

1. NAME: ____

   NICKNAME: ____

2. DATE OF BIRTH: __________________ ☐ MALE ☐ FEMALE

3. ADDRESS: ____
   (If P.O. Box, give street address too)

   CITY: ___________________ STATE: _______ ZIP: _________

4. PHONE: H ______________ C ______________ W _____________

☐ **FATHER** EMAIL___________________________________
☐ **LEGAL GUARDIAN** Relationship to patient _____________

7. NAME: ____

8. DATE OF BIRTH: ______________/___________/_____________

9. ADDRESS: ____
   (If P.O. Box, give street address too)

   CITY: ___________________ STATE: ______ ZIP: __________

10. PHONE: H_____________C_____________ W______________

11. EMPLOYER: ____

12: ADDRESS: ____

    CITY: __________________ STATE: _______ ZIP: _________

13. SOCIAL SECURITY NO: ________-_______-_______________

14. CHECK ONE: MARRIED _________ UNMARRIED __________

    SEPARATED _______ WIDOWED ____________

    DOES CHILD RESIDE WITH YOU? ☐ YES ☐ NO

☐ **MOTHER** EMAIL___________________________________
☐ **LEGAL GUARDIAN** Relationship to patient _____________

7. NAME: ____

8. DATE OF BIRTH: ___________/___________/______________

9. ADDRESS: ____
   (If P.O. Box, give street address too)

   CITY: ___________________STATE: ________ZIP:__________

10. PHONE: H____________ C ______________ W _____________

11. EMPLOYER: ____

12. ADDRESS: ____

    CITY: ___________________ STATE: _______ZIP: __________

13. SOCIAL SECURITY NO: _________-_______-________________

14. CHECK ONE: MARRIED _________ UNMARRIED __________

    SEPARATED _______ WIDOWED ____________

    DOES CHILD RESIDE WITH YOU? ☐ YES ☐ NO

ARE YOU COVERED BY DENTAL INSURANCE? YES NO

Insurance will not be billed unless we are provided with the following information:
1) Dental insurance card – provided? ___Yes ___No
2) Relocation orders (for military dependents)
3) All insurance information must be completed and updated at each visit.

Note: Dual coverage for children: Primary insurance determined by the parent whose month & day of birth is earliest in the year.

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.

1ST INSURANCE (PRIME)

_________________________ __________ ___________
EMPLOYEE NAME MALE FEMALE

_________________________ ______________________
RELATIONSHIP TO PATIENT SS#

____________________ ______________________
DATE OF BIRTH INSURANCE ID#

____
EMPLOYER NAME

______________________________ ______________
DENTAL INSURANCE CO. NAME EFFECTIVE DATE

____
INSURANCE ADDRESS

_________________________ ___________________
INSURANCE PHONE # INSURANCE GROUP #

2ND INSURANCE (PRIME)

_________________________ __________ ___________
EMPLOYEE NAME MALE FEMALE

_________________________ ______________________
RELATIONSHIP TO PATIENT SS#

____________________ ______________________
DATE OF BIRTH INSURANCE ID#

____
EMPLOYER NAME

______________________________ ______________
DENTAL INSURANCE CO. NAME EFFECTIVE DATE

____
INSURANCE ADDRESS

_________________________ ___________________
INSURANCE PHONE # INSURANCE GROUP #

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 ________________________________

Which family members/siblings? ___________________________

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 <u>NOT</u> 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:____

I, ____

have received a copy of the

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

Patient Signature ________________Date____________

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