PATIENT MEDICAL HISTORY

NAME _____

PRIMARY CARE
PHYSICIAN'S NAME _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐

IF YES, WHAT MEDICAITON(S) ARE YOU TAKING?

MEDICATION	DOSAGE	FREQUENCY

	YES	NO
3. HAVE YOU EVER BEEN HOSPITAIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL?	☐	☐
6. DO YOU USE COCAINE OR OTHER DRUGS?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐
8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS?	☐	☐

IF YES, PLEASE SPECIFY:

_____

_____

9. WHEN WAS YOUR LAST COMPLETE PHYSICAL?

_____

10. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINNK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

11. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ CHEST PAINS	☐ KIDNEY DISEASES
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ EASILY WINDED	☐ AIDS OR HIV INFECTION
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ STROKE	☐ THYROID PROBLEM
☐ SWOLLEN ANKLES	☐ ANGINA	☐ HAY FEVER / ALLERGIES	☐ HEPATITIS / JAUNDICE
☐ FAINTING / SEIZURES	☐ FREQUENTLY TIRED	☐ TUBERCULOSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ ASTHMA	☐ ANEMIA	☐ RADIATION THERAPY	☐ STOMACH TROUBLES / ULCERS
☐ LOW BLOOD PRESSURE	☐ EMPHYSEMA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ EPILEPSY / CONVULSIONS	☐ CANCER	☐ RECENT WEIGHT LOSS	☐ OTHER _____
☐ LEUKEMIA	☐ ARTHRITIS	☐ LIVER DISEASE	☐ _____
☐ DIABETES	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	☐ _____

COMMENTS

_____

_____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? ☐
   - A) CLICKING? ☐
   - B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐
   - C) DIFFICULTY IN OPENING OR CLOSING? ☐
   - D) DIFFICULTY IN CHEWING? ☐
8. DO YOU HAVE FREQUENT HEADACHES? ☐
9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐
10. DO YOU BIT YOUR LIPS OR CHEEKS FREQUENTLY? ☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐

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.

_____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT INFORMATION

Millar Family Dentistry

(CONFIDENTIAL)

(PLEASE PRINT)

DATE _____

NAME _____ BIRTHDATE _____
FIRST MI LAST

SOCIAL SECURITY NUMBER (SSN) _____ PHONE _____

ADDDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE _____

SOCIAL SECURITY NUMBER (SSN) _____

EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

Millar Family Dentistry
817.594.4788

601 South Bowie
Weatherford, TX

DENTAL OFFICE POLICY

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to all traditional, indemnity insurance plans. We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is no coverage when treatment is rendered by a non-participating dentist. Please check your type of plan carefully. Patients with Delta Dental Insurance: Millar Family Dentistry is a participating "PREMIERE" provider (not PPO). However, for all PPO plans, even though Millar Family Dentistry is out-of-network, we are still able to bill your insurance and benefits are payable. For more specific information about out-of-network benefit amounts, please call your insurance company.

Authorization to Release Info and Assignment of Benefits: I certify that I, (or my dependent) have (has) dental insurance coverage and assign directly to Millar Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Payments: We accept cash, check, VISA, MasterCard, Discover, American Express, and Care Credit. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge a $5.00 per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, check, VISA, MasterCard, Discover, American Express, and Care Credit. If, however, payment is made with cash or check and a total of $500 or more, a 5% discount is provided. We are unable to provide this discount if payment is made with a credit card.

Broken/Missed Appointments: We request at least 48 hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and fill the opening left in our schedule. We reserve the right to charge your account $50 if we are not notified at least 24 hours before your appointment. Thank you for assisting us in keeping our schedule full.

Millar Family Dentistry reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship to patient: _____

HIPPA CONSENT AND ACKNOWLEDGEMENT
PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ***(PHI)*** about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this Notice before signing this consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

1. Treatment: (including direct and indirect treatment by other health care providers involved in your medical care);
2. Payment from your insurance company or other third party payers;
3. The day to day health care operations of our Practice.

You have the right to revoke this Consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operation.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this Consent in writing at any time.
- The practice may condition receipt of treatment upon the execution of this Consent.

Please provide us the name(s) of family members or other persons, if any, to whom we may release Information regarding your medical condition, financial account, or who have permission to make, edit, or inquire about your appointments.

Name:	Relationship:	How much access does person have to ***PHI***?
_____	_____	_____
_____	_____	_____

Signature of Patient/Representative: _____ Date: _____

☐ Self ☐ Parent/Guardian

Millar Family Dentistry
601 South Bowie Drive
Weatherford, TX 76086
(817) 594 - 4788

Photo Release

I hereby authorize Dr. Greg Millar or his assistants to take photographs and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs and/or videos will be used to better communicate my care, for educational purposes in study club meetings, lectures, seminars, and professional publications.

I further understand that if the photographs or videos are used in any publication my name or other identifying information will be kept confidential.

I do not expect compensation or financial reward for the use of these photographs/video and release Dr. Greg Millar and any member of his team from legal or equitable claims in the use of photos for purposes stated above.

Patient Name: _____

Patient Signature: _____ Date: _____

Millar Family Dentistry
601 S. Bowie Dr.
Weatherford, TX 76086
(817) 594 - 4788

Cancellation/No Show Policy

Our desire is to make appointments as comfortable and convenient as possible.

If it becomes necessary to cancel an appointment, we request to be notified a minimum of **24 hours** before the time of the appointment. This allows us enough time to schedule conveniently for the patient filling the cancellation.

Patients that cancel or no show their appointments without this 24-hour notice will be charged as follows:

$50 for doctor and hygiene appointments

By signing below, I acknowledge that I have read and understand this policy.

Office Hours:
Monday & Wednesday 8:00am-5:00pm
Tuesday 8:00am-7:00pm
Thursday 8:00am-12:00pm

_____
Patient Name (printed)

_____
Patient Signature

_____
Date