

PATIENT MEDICAL HISTORY

NAME _____

PRIMARY CARE

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

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

MEDICATION	DOSAGE	FREQUENCY

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

9. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

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

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

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

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

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 _____
FIRST MI LAST BIRTHDATE _____

SOCIAL SECURITY NUMBER (SSN) _____ PHONE _____

ADDRESS _____ 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? _____

DENTAL OFFICE POLICY

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance to assist you in paying your obligation. We are able to bill to all traditional, indemnity insurance plans. We do not accept DMO or HMO plans (Dental Maintenance or Health Maintenance Organizations). Under these plans, there is no coverage when treatment is rendered by a non-participating dentist. Please check your type of plan carefully. For all PPO plans, even though Millar Family Dentistry is out-of-network, we are still able to bill your insurance. Amounts due for treatment are the patient's responsibility and insurance figures are estimates only. If insurance fails to pay within 60 days of the claim being submitted, the full amount is the patient's responsibility. 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 24 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 to 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: _____

Millar Family Dentistry
601 S. Bowie Dr. Weatherford, TX 76086

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 or reschedule 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, reschedule or no show their appointments without this 24-hour notice will be charged as follows:

\$50 per appointment hour 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