Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Cell # _____ Birthdate _____ Social Security # _____

Are any immediate family members current patients here? _____ If so, should we add you to their account _____

Do you have an e-mail address? _____ If so, _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthday _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthday _____ Work Phone _____

Insurance Information

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

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If Yes: _____

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

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Patient Name: _____
Family Physician: _____
Date of Birth _____

Today's Date: _____

UPDATES: _____

Are you taking any medications (over the counter or prescription)?
If so, Please list all:

_____
_____
_____
_____
_____
_____

Have you been hospitalized or had any type of surgery within the last 2 years?
Please explain:

_____
_____

Do you have or have you ever had (please circle yes or no):

Heart attack	no	yes	Shunts/Stints	no	yes
Pacemaker	no	yes	Prosthetic Valves	no	yes
Irregular Heart Beat	no	yes	Heart Surgery	no	yes
Rheumatic Heart Disease	no	yes	Mitralvalve Prolapse	no	yes
Heart Murmur	no	yes	Bacterial Endocarditis	no	yes
Congestive Heart failure	no	yes	Thyroid disorder	no	yes
Stroke	no	yes	Radiation Therapy	no	yes
Seizures/Convulsions	no	yes	Asthma	no	yes
Abnormal Blood Pressure (high)	no	yes	Diabetes	no	yes
(low)	no	yes	Malignancy/Cancer	no	yes

Artificial joint replacement no yes If yes, when: _____

Have you ever tested positive for:

HIV___ Hepatitis___ Venereal Disease ___ Tuberculosis ___

Do you have any tobacco habits? _____

Are you pregnant? _____

Are you allergic To: Penicillin _____ Codeine _____ Latex _____ Sulfa _____

Are you allergic to any other medications, food, etc?

_____
_____

Are there any other health problems/medical conditions? Please explain:

_____

Please sign: _____ Date: _____

Name _____

DENTAL HEALTH HISTORY: (For Office Use Only)

When was your last full set of x-rays? _____

Are you having any discomfort at this time? ☐ Yes ☐ No

Describe: _____

_____

When was your last visit to the dentist? _____

What was done? _____

When was your last cleaning? _____

Do you feel you are in good dental health? ☐ Yes ☐ No

Do you have any nervous habits such as
☐ nail biting ☐ cheek biting ☐ pencil chewing ☐ Yes ☐ No
☐ Other

Do you ever notice yourself grinding or clenching your teeth? ☐ Yes ☐ No

Have you had any injuries to your face, teeth, or jaws? ☐ Yes ☐ No

Describe: _____

Have you lost any teeth? ☐ Yes ☐ No

Why: _____

Have they been replaced? ☐ Yes ☐ No

Fixed bridge ☐ Yes ☐ No

How long? _____

Partial ☐ Yes ☐ No

How long? _____

Denture ☐ Yes ☐ No

How long? _____

Are you having any trouble with your bridge, partial, or denture? ☐ Yes ☐ No

Has anyone ever talked to you about having them replaced? ☐ Yes ☐ No

Are any of your teeth sensitive? ☐ Yes ☐ No
☐ hot ☐ cold ☐ sweet ☐ bite

Are you aware of any swelling in or around your mouth? ☐ Yes ☐ No

Have you ever had any orthodontic (braces) treatment? ☐ Yes ☐ No

Have you ever had any periodontal (gum) treatment? ☐ Yes ☐ No

Are you apprehensive in the dental office? ☐ Yes ☐ No

Any particular fears? _____

Have you tried nitrous oxide gas? ☐ Yes ☐ No

What is your daily dental homecare routine?

_____

Should you need treatment, at what point should we address it?
☐ When it hurts or breaks
☐ When something becomes worse
☐ When something is not ideal

What quality of dentistry do you want us to recommend?
☐ Just patch it
☐ Average
☐ The best it can be

How do you feel about the appearence of your smile?

_____

Is there anything else about your dental health that you feel is important for us to know? _____

_____

JOE D. MILLER, III, D.D.S.
CHRIS K. MILLER, D.D.S.
MICHAEL K. O'NEAL, D.M.D.
JAMES TALBOT, D.D.S.

COSMETIC AND GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

RIVERTOWN DENTAL CARE
FINANCIAL RESPONSIBILITY FORM

Patient's Name:_____ Date of Birth:__/__/__

Address: _____
Telephone #____/____/_____ Work #____/____/_____
Social Security #____/____/_____ Employer:_____
Dental Insurance Carrier: _____
ID #_____Group # _____
If Patient is under the age of 18, name of individual who is financially responsible for the Patient: _____

If you have dental insurance, we will file the claims for you, as a **complimentary service.** It is very important that you provide the correct insurance information at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update **Rivertown Dental Care** at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to **Rivertown Dental Care.** We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer, and your insurance company.

If requested, we will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is **your responsibility.** While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service become the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 60 days from the date of service is subject to interest charges of 1.5% per month until the balance is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, where additional collection fees will be applied to any unpaid balance. **Any attorney or collection fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees.** Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $36 NSF check fee and may also be subject to court and attorney fees.

We request a 24 hour cancellation for scheduled appointments. A cancellation fee of $50 may be charged if less than 24 hour notice is not given or the appointment is failed.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

Signature:_____ Date: __/__/__

Insurance Registration

In order for us to best serve you with your dental benefits, we must have this form filled out completely and you must present us with verification of insurance (a card, booklet, or statement from your employer). Without verification, we will not be able to accept insurance as a method or payment. **All fees will be due at time of service.**

Insurance Policy Holder's name (employee):

Insured's Social Security Number:

Insured's Date of Birth:

Insured's Place of Employment and Address:

Are there any other family members covered by your insurance? If so, please list them here along with their dates of birth:

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to my claims. I hereby authorize payment to the dental benefits otherwise payable to me directly to the named dental entity.

Signature:_____ **Date:**_____

JOE D. MILLER, III, D.D.S.
CHRIS K. MILLER, D.D.S.
MICHAEL K. O'NEAL, D.M.D.
CRAIG TAYLOR, D.M.D.

COSMETIC AND GENERAL DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.50 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____