PATIENT & PARENT INFORMATION

Patient

Patient's Name _____ Social Security # _____--_____--_____
Address _____City,ST_____Zip_____
Date of Birth _____ Please Circle Male Female
Names of other children seen by this practice _____
Whom may we thank for referring you to our practice? _____
Person financially responsible for this child? _____

Mother

Mother's Name _____ Social Security # _____--_____--_____
Address _____City,ST_____Zip_____
Date of Birth _____
Marital Status: S M D W Driver's License # _____
Home Phone # _____ Cellular Phone # _____
Place of Employment _____ Work Phone # _____
Occupation _____
Work Address _____
Email Address (Home & Work) _____

Father

Father's Name _____ Social Security # _____--_____--_____
Address _____City,ST_____Zip_____
Date of Birth _____
Marital Status: S M D W Driver's License # _____
Home Phone # _____ Cellular Phone # _____
Place of Employment _____ Work Phone # _____
Occupation _____
Work Address _____
Email Address (Home & Work) _____

Legal Guardian

Name _____ Social Security # _____--_____--_____
Address _____City,ST_____Zip_____
Date of Birth _____
Marital Status: S M D W Driver's License # _____
Home Phone # _____ Cellular Phone # _____
Place of Employment _____ Work Phone # _____
Occupation _____
Work Address _____
Email Address (Home & Work) _____

Emergency Contact

Emergency Contact (nearest relative NOT living with you) _____
Relationship to child _____
Address _____ City, State ZIP_____
Home Phone # _____ Cellular Phone # _____

_____Initial
(Parent/Guardian)

Payment and Collection Policy

Payment Options

We accept payment in the forms of cash, check or credit card (we do not accept American Express). We also have the ability to extend payments over time with the Care Credit Program (ask the front desk for more information). Full payment is due at the time care is rendered, unless you have made previous arrangements with our office.

Collection Policy

If there is a balance due after we receive payment from your insurance company, you will be sent a statement. Payment is expected within 30 days of the statement being issued.

If for any reason we are unable to collect, be aware that we may assess an interest fee not to exceed 20% of the uncollected balance. Additional expenses will be incurred if we must involve a collection agency.

APPOINTMENT POLICY

Cancellations must occur prior to 8:30 a.m. the day of the appointment or the responsible parties will be responsible for a $50.00 late cancel-no show charge. Changing your appointments is a reasonable thing to do, but a pattern of doing so blocks other patients receiving their care. A pattern of no shows or late cancellations or excessive appropriate cancellations can be grounds for service to end and you would at that point be referred to another provider.

CONSENT TO ACCOMPANY YOUR CHILD

If another person (other than a parent) accompanying your child's dental visit, please give them signed consent in writing and a copy of your Driver's License. Please list below those you choose to accompany your child.

Name:	Relationship to child:

_____Initial
(Parent/Guardian)

LEGAL SERVICES

I make it a policy not to provide court services. I am not a forensic specialist and hence do not feel that I am effective in a court room setting. If I am required to go to court by your attorney via a subpoena, I charge $550.00 for my time at court per hour. I charge $ 350.00 per hour for preparation time. Further, I require a retainer prior to agreeing to testifv of $2.650.00.

_____Initial
(Parent/Guardian)

Medical and Dental History

Dental History

Why are you seeking care for your child? _____
Do you have any concerns about your child's teeth? _____
Has your child ever had an accident involving their mouth, face or head? _____
If yes, please explain:_____
Has your child ever seen a dentist before; if so, whom, when and the reason for the visit? _____
_____
Has your child ever had any dental radiographs (x-rays); if so, when? _____
Is your child currently having any pain, fever or swelling? _____
Any family members living in same household with a history of cavities prior to the age of eighteen? _____
If so, who? (this includes siblings)_____
Has your child ever had a negative dental experience? _____

Medical History

Name of Pediatrician or other treating Physicians:_____
Date of last visit (approximately): _____ Reason:_____
Current Medications: _____
Allergies to Medications: _____
Illness in the past week and/or any communicable disease in the past week? _____

Check all that apply:

	Heart Murmur		Rheumatic or Scarlet Fever		Hepatitis, HIV, AIDS
	Frequent Nose Bleeds		Brain Damage		Bleeding Disorders
	Birth Defects		Diabetes		Herpes (fever blisters)
	Cancer		Whooping Cough		Heart Disease
	Seizures		Neurological Problems		Asthma
	Premature Birth		Behavioral/Learning Problems		Chicken Pox, Mumps or Measles
	Unusual Bruises or Bruises Easily		Mental or Developmental Problems		Family History of Malignant Hyperthermia
	Latex allergy (Balloons, Band-Aids, surgical tape, gloves)		Emergency Room Visits		Surgeries
	Received Anesthesia		Immunizations Up-to-date		

If you check any of the above, please give a brief description. Also if you have any other medical, dental or behavioral issues not addressed above, please give a brief description: _____
_____
_____
_____
_____
_____

_____Initial
(Parent/Guardian)

INSURANCE (DENTAL & MEDICAL)

Our Office and Your Insurance

Our office is an out of network facility. You will be responsible on the day of care for the estimated portion your insurance does not cover. As a courtesy, our office will file your insurance for the remaining balance for your child's care. After receiving payment, we will send a statement for any remaining balance owed. You are responsible for any service not covered by your insurance policy. If you would prefer, you may file your own insurance; please let our front office staff know what you would prefer. We may share information if Hospital Based care is indicated. Our office doesn't file secondary insurance. Be prepared to bring your Dental and Medical Insurance Cards to your child's appointment. We will make copies of both at your first visit.

Check all that apply.

_____ Dental Insurance
_____ Medical (Health) Insurance
_____ No Insurance
_____ CHIPs (We are not a provider)
_____ Medicaid (We are not a provider)
_____ Other

Check all individuals carrying insurance coverage for this child… **Dental**

Is this coverage provided through a _____employer or _____a private policy?

Primary ____Mother ____Father ____Other (relationship to child) _____
Secondary ____Mother ____Father ____Other (relationship to child) _____

Medical

Is this coverage provided through a _____employer or _____a private policy?

Primary ____Mother ____Father ____Other (relationship to child) _____
Secondary ____Mother ____Father ____Other (relationship to child) _____

_____Initial
(Parent/Guardian)

ATTENTION INSURANCE COMPANIES

I authorize James H. Miller, DDS and staff to furnish information to my insurance carriers concerning my child's dental care.

This is an insurance payment agreement between James H. Miller, DDS and

Name of Insured: _____ (**not the child**).

I am requesting that all dental insurance payments be made directly to James H. Miller, DDS for dental services filed by his office.

My signature is on file to release payment to his office.

Patient's Name: _____

Insured's Name: (Print) _____

Signature: _____

Witnessed by: _____

Date: _____

To the insured:

We cannot accept responsibility for collecting your insurance claims or for negotiating a settlement dispute. We will also not become a party to any disputes between divorced or separated parents. The individual accompanying the child to the appointment will need to be prepared to settle the account at the time of service.

PLEASE REMEMBER…

Your insurance company is interested in only:

Keeping as much of your hard earned money as possible.

They are least interested in your child's health.

Do not let a corporation hold your money hostage and dictate your child's care.

_____Initial
(Parent/Guardian)

HIPAA

(Health Insurance Portability and Accountability Act)

Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization
I authorize James H. Miller, DDS and his staff to use and disclose the protected health information described below to any entity or person they deem necessary to provide safe and effective dental care for my child _____.

2. Effective Period
This authorization for release of information covers all past, present, and future periods.

3. Extent of Authorization

□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

□ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____.

4. This medical information may be used by the person I authorize to receive this information for dental and medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his or her relationship to patient

_____Initial
(Parent/Guardian)

INFORMED CONSENT

You have the right as a parent, to be informed about your child's condition and the recommended care to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

With regard to my child _____(Patient's Name), I _____(Parent/Legal Guardian) voluntarily request Dr. James H. Miller, D.D.S., Pediatric Dentist and other healthcare providers as he may deem necessary to treat my child's condition which has been explained to me as: First Examination. I understand and consent to the following care planned for my child: Medical and Dental History Review, Complete Intra-Oral and Extra-oral examinations and Hard (Dental) and Soft (Head and Neck) Tissue Examinations any other procedures, including but not limited to radiographic assessment ("X-rays") and the administration of local anesthetics, deemed necessary or advisable to the planned treatment. I further understand and consent to the use of behavior management techniques to facilitate the rendering of necessary dental treatment including but not limited to various forms of physical or chemical restraint. If I wish any exceptions I have so noted as follows (If no exceptions, please write "None"):

_____

Alternate forms of treatment, as well as the option of no treatment, have been explained to me with the advantages and disadvantages, risks and probable effectiveness of each. I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee expressed or implied either as to the result or as to cure.

Although their occurrence is extremely rare, some risks are known to be associated with the treatment or anesthetic agents including but not limited to: numbness, infection swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, breathing problems, brain damage, stroke, heart attack, paralysis, the loss or loss of function of any organ or limb, I further understand and accept that, though unlikely, complication may require hospitalization and may even result in death. Dr. Miller has discussed these possible complications with me to my satisfaction.

I hereby state that this form has been fully explained to me and I have read and understand this consent. I have been given an opportunity to ask questions about my child's condition and all questions about the procedures have been answered in a satisfactory manner. I believe that I have sufficient information to give this informed consent.

_____ Signature _____ Date

_____Printed Name _____ Relationship to Patient

_____Initial
(Parent/Guardian)