MARK A. MILLER, DMD
SNOW PARK DENTAL

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs, Please fill out this form in ink. If you have any questions, please ask us. We will be happy to help! ❒ S.O.O ❒ Chart ❒ Patterson

Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: M or F Family Status: M or S Emergency Contact (Name & Number): _____

Social Security #:_____ Driver's License # : _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail address: _____ Best Time to Call**:** _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for seeking care: _____

Whom may we thank for referring you to our practice?

Have you ever had any of the following? Please check those that apply:

☐ Acid Reflux (Heartburn)
☐ AIDS
☐ Allergies–Insect Bites
☐ Allergies – Food
☐ Allergies – Shell Fish
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Growths
☐ Angina/ A fib
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
A B C D E G (please circle)
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy (Current)
Due date:_____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors / Ulcers
☐ Venereal Disease
☐ Do you premedicate?

Allergies (✓ all that apply)
☐Codeine Allergy
☐Penicillin Allergy
☐Aspirin Allergy
☐Local Anesthetic Allergy
☐Sulfa Allergy
☐Latex Allergy
☐Additional Drug Allergy:
_____

- Have you ever had a negative experience at a dental office? ☐ Yes ☐ No
  If yes, please explain: ☐ Treatment ☐ Staff ☐ Billing _____
- **Do you have any body piercing (other than ear lobes)?** ☐ Yes ☐ No _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician: _____
  If yes, please explain: _____
- List any medications or drugs, including nutritional supplements you are currently taking.
  _____
- Are you a smoker? ☐ Yes ☐ No How many cigarettes / day? _____
- Do you have any other health problems? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any dental concerns? ☐ Yes ☐ No

	Toothache		Concerned about Breath		Unable to open mouth wide
	Broken Tooth / Filling		Bad Taste in Mouth		Shoulder, Neck or Headaches
	Loose Teeth		Jaw Joint Pain		Bite is Uneven
	Wear on Teeth		Clicking or Grinding		Teeth have shifted
	Food Traps		Jaw gets tired easily		Tooth Sensitivity (Hot, Cold or Sweets)

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail._____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____

Relationship to Patient: _____

MARK A. MILLER, DMD
SNOW PARK DENTAL

OUR FINANCIAL POLICY

Thank you for choosing our practice for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care that you want and deserve allowing you to enjoy a healthy, beautiful smile. Dental treatment is an excellent investment in an individual[s medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your question s or assist you in any way we can

FOR ALL PATIENTS: We are happy to assist you in filing the necessary insurance forms to help you receive the full benefits of your coverage: however, we can make no guarantee of any estimated coverage or payment. Because the insurance policy is between you and your insurance company, we ask that all patients be directly responsible for all charges. We do ask that you pay the estimated patient balance and / or co-payment at the time services is rendered. Please know that we will do everything possible to see that you receive full benefits of your policy. Any claim that is outstanding after (60) days will be due, in full, from you.

A pre-authorized arrangement through a credit card will only be used if a dental claim is outstanding after (60) days and/or a balance exists on your account. Snow Park Dental is authorized to chart the following:

Credit Card #:_____ Expiration Date:_____

Authorized Signer:_____

Collections
Returned checks and balances older than 60 days, may be subject to additional collections fees, billing charges and /or interest charges. Attorney fees, court costs, collection fees, interest on unpaid balances and other costs incurred in collection will be added to the account.

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you, regardless of your insurance coverage. As the patient, it is your responsibility to deal with your insurance company and your employer .We will assist in any way possible to maximize your dental insurance benefits, but to reemphasize, we have no relationship or responsibility to your insurance company.

- FACT#1 Dental insurance is not meant to be a "PAY-ALL". It is only meant to be an aid.
- FACT #2 Many plans tell their insured that they will be covered "up to 80% or up to 100%". In spite of what you are told, we have found many plans cover 40-50% of an average fee. Some plans pay more… some pays less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance " the less you will receive. It is your responsibility to advise us of your coverage and restrictions or changes to your insurance.
- FACT#3 It has been the experience of many dentists that some insurance companies tell their customers that " fees are above the usual and customary fee" rather than saying to them that " our benefits are low ". Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with over 1000 dental insurance plans, most do cover our fees.
- FACT#4 Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover, however, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.
- FACT #5 Many routine dental services are not covered by insurance carriers. We make our recommendations based on your needs and not on what your insurance many or may not cover.

_____ I authorize the release of all necessary information.

_____ I authorize payment of benefits directly to the provider

_____ I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Signature_____Date _____

Dentistry for the Individual

Photography Release

I _____, hereby authorize the doctor and staff of Mark A. Miller DMD PA to take photographs of my face, jaws and teeth. I understand that the photographs will be used as a record of my care and for professional communications with other doctors, dental laboratories, or other professionals involved with my care.

Paragraph I

I understand that these pictures may be used for educational purposes in lectures, demonstrations, advertising (including website publication) and professional publications (dental magazines and journals).

I further understand that if the photographs are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check this BOX to grant us permission to use your pictures as stated in Paragraph I.

☐ Check this BOX if you Do Not grant us permission to use your pictures as stated in Paragraph I.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this Acknowledgement ***

I have received / been offered a copy and declined, a copy of this office's ***Notice of Privacy Practices***

Patients Name Printed _____

Signature _____

Date _____

For Office Use Only

- ❑ ***We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:***
- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)