Miller Family Dentistry, LLC
"Committed to providing excellent dental care for patients of all ages"
435 Limekiln Drive, Chambersburg, Pennsylvania 17201
Phone 717.267.3922 Fax 717.267.3202

Welcome To Our Office

Our goal is to provide you comfortable, comprehensive and convenient dental care. We will ensure you have every question answered regarding your dental treatment. We constantly strive to improve all aspects of care that we provide to you. If you are ever concerned with the care you are receiving, please contact Dr. Miller or our staff so we may achieve our goals for you.

Patient Information

Name ❑Mr. ❑Mrs. ❑Ms. _____ _____
First *MI* *Last* *Preferred Name*

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed

Street Address _____

City _____ State _____ Zip _____

Phone# home _____ cell _____ work _____
E-mail address _____

Social Security Number _____ Date of Birth _____ Age_____
How would you like us to confirm your appointments? (select as many
❑Mail ❑E-mail ❑Phone (❑home ❑work ❑cell) ❑Text

Whom may we contact in case of emergency? _____ Phone _____

Whom may we thank for referring you? _____ Phone _____

Do you have dental insurance? ❑Yes ❑No **(if yes please fill out below information)**

Primary Insurance

Subscriber Name _____
SSN _____ *DOB* _____
(If different from patient information)
*Relationship to Patient*_____
Employer _____
Occupation _____
Insurance Company _____
Group Number _____
Member ID Number _____

Secondary Insurance

Subscriber Name _____
SSN _____ *DOB* _____
(If different from patient information)
*Relationship to Patient*_____
Employer _____
Occupation _____
Insurance Company _____
Group Number _____
Member ID Number _____

Medical History

(FRONT AND BACK)

General Health: (check box) ❑Excellent ❑Good ❑Fair Date of last physical_____

Physician's Name _____ Phone _____

Answers to the following are for our records and remain confidential.

Are you under current medical treatment? ❑Yes ❑No

If yes, please explain: _____

Are you currently taking any medication or herbal supplements? ❑Yes ❑No

If yes, please list all prescription and non-prescription medications, including vitamins and supplements on medication log *(see reverse page).*

Do you have allergies or adverse reaction to drugs? ❑Yes ❑No

If yes, please list drug and reaction: _____

_____

Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? ❑Yes ❑No

Are you on a special diet? ❑Yes ❑No

Have you lost or gained more than 10 pounds in the past year? ❑Yes ❑No

Do you use any form of tobacco? ❑Yes ❑No

What Type (please circle) Cigarettes Cigars Snuff Chew How much? _____

Are you interested in quitting? ❑Yes ❑No

Do you consume alcohol? ❑Yes ❑No If yes, how much per week on average? _____

Women, are you: (please circle) Pregnant Nursing On Hormone Therapy Taking Birth Control

Heart Disease	❑Yes	❑No	Respiratory Disease	❑Yes	❑No
Pacemaker	❑Yes	❑No	Asthma	❑Yes	❑No
High Blood Pressure	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Stroke	❑Yes	❑No	Bleeding Problems	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Latex Sensitivity	❑Yes	❑No
Other Heart Ailment	❑Yes	❑No	Organ Transplant	❑Yes	❑No
Cancer	❑Yes	❑No	Caffeine Dependency	❑Yes	❑No
Chemo/Radiation Therapy	❑Yes	❑No	Alcohol Dependency	❑Yes	❑No
Major Operations	❑Yes	❑No	HIV or AIDS	❑Yes	❑No
Arthritis	❑Yes	❑No	Psychologic/Psychiatric Treatment	❑Yes	❑No
Artificial Joints	❑Yes	❑No			
Liver Disease	❑Yes	❑No	Do you have a disease or condition not listed	❑Yes	❑No
Hepatitis	❑Yes	❑No	If yes, please explain:		
Kidney Disease	❑Yes	❑No			
Diabetes	❑Yes	❑No			
Family History Diabetes	❑Yes	❑No			
Intestinal Disease	❑Yes	❑No			
Gastric Reflux	❑Yes	❑No			

MEDICATION NAME	PRESCRIBED FOR	DOSAGE

Dental History

(FRONT AND BACK)

What is your immediate dental concern or like us to address today?

_____

Do you have dental pain now? _____

When was your last dental visit? _____

What was done at that appointment? _____

When: Was your last cleaning and exam? _____ Were your last dental x-rays taken? _____

Unfavorable dental experiences ❑

Dental fears ❑

Preference for no dental anesthetic ❑

Problems with effectiveness of or bad reactions to dental anesthetic ❑

Orthodontic treatment (braces) ❑

When _____

Bleeding gums ❑

Habitual chewing of hard substances i.e. ice, popcorn kernels ❑

Part of your mouth sensitive to temperature ❑

Lumps or bumps on head or neck ❑

Dry mouth ❑

Do you have a sugar or soda pop habit ❑

Unpleasant taste or odor in your mouth ❑

Viral infection or cold sores ❑

Jaw Problems (TMJ) ❑

Difficulty opening your mouth widely ❑

Stiff or sore head, neck or shoulder muscles ❑

Do you wake up with tooth or jaw pain? ❑

Tension headaches ❑

Clench or grind your teeth ❑

Jaw clicking or popping ❑

Any oral appliances ❑

Any removable teeth ❑

Family history of diabetes ❑

Parents who have lost teeth or had gum disease ❑

Noticed loose teeth or a change in your bite ❑

Breath through your mouth while awake or sleep? ❑

How often do you brush? _____Floss? _____

Other oral health aids: _____

Dental History Continued

When it comes to your oral health, do you prefer to be Proactive? Someone who likes to avoid complications. Who'd rather take care of an issue today instead of letting it worsen over time which might cost more time, visits, money and/or pain to fix down the road?

❑ Yes ❑ No

What do you value most in a dental office? Please write answer below.

Cosmetic– You most value how your teeth look (straight, white, etc.)

Function– You most value an ability to enjoy your favorite foods & drinks. You do not want to be limited to eating on one side/area.

Comfort– You most value NOT being in pain or having any tooth or gum sensitivities.

Example: I can't eat this anymore because it hurts or is sensitive

Longevity– You most value the ability to have your natural teeth forever. You expect the treatment you have completed to last forever.

_____

_____

What is the most important objection/obstacle you have to visiting a dental office? Please write answer below.

No objections or obstacles– Schedule and keep routine visits every 6 months as recommended. No dental fears or concerns with attending dental appointments.

Time– Having appointment times that suite your schedule with work and day to day activities.

Budget– Not having the finances to invest in dental treatment.

Lack of Trust– Unfavorable past dental experiences. Not given information on or reason towards treatment. Recommending treatment that is NOT necessary in improving dental health.

Lack of Urgency– Nothing has caused pain or discomfort so there has not been a reason to see a dentist. Believing pain or discomfort that may be present is "livable" or "manageable" without seeing a dentist.

_____

_____

How important is it for you to keep your teeth for the rest of your life? (circle one)

Not important 1 2 3 4 5 6 7 8 9 10 Very Important

How do you rank your smile? (circle one)

Unpleasant 1 2 3 4 5 6 7 8 9 10 Beautiful

What would you change about your smile or bite if you could? _____

FINANCIAL AGREEMENT
Miller Family Dentistry

Patient Name _____ Date: _____

Dental treatment is an excellent investment in an individual's medical and psychological wellbeing. Financial considerations should not be an obstacle to obtaining health service. We offer the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations.

1. We accept Check, Cash, Money Order, Visa, Mastercard, Discover and American Express.
2. We offer a 5% prepay special discount for all treatment paid for at the time of scheduling when using the above payments.
3. We offer **interest free** extended payment plans of 6 months through Care Credit for qualified applicants.

Dental Insurance:

While we are happy to assist you by submitting insurance claims to your insurance company, please note our agreement is with YOU, and NOT your insurance company. Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship and cannot enter into a dispute with your insurance company. You must remember that dental insurance is designed to offset the costs of your dental treatment. Our office staff will help you to the best of our ability, to obtain your maximum benefits, but you are responsible for the cost of your treatment and any insurance reimbursement conflicts**.** You must provide us with current insurance card/ information at each visit in order for our office to submit your claim for you. ***We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits***.

Statements

To avoid increased fees to all patients, any account balance over 30 days will be assessed a $10 rebilling fee every billing cycle afterward. All accounts over 90 days will be notified in writing of their account being transferred to a collections agency.

Returned Checks

A fee of $45.00 will be charged for any returned checks

Broken Appointments

Your appointment time is reserved especially for you as our patient to provide you with outstanding care for your dental care needs. We strive to provide you with a two day courtesy reminder via email, text or call, however it is your responsibility to remember your dental appointments. Please take note that there is a $60.00 fee for appointments cancelled with less than 48-hour notice.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account. Additionally, by signing this form I authorize Miller Family Dentistry to process credit card transactions initiated by me by phone and I authorize my credit institution to pay.

_____ _____

Print Name of Patient or Responsible Party Date

_____

Signature of Patient or Responsible Party

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Miller Family Dentistry, LLC

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 02/01/03, 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: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: 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 will 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 $0.50 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: Dr. Ann Miller

Telephone: 717-267-3922 Fax: 717-267-3202

E-mail: millerfamilydentistry@hotmail.com

Address: 435 Limekiln Drive, Chambersburg, PA 17201

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

RECEIPT OF NOTICE OF PRIVACY PRACTICE
WRITTEN ACKNOWLEDGMENT FORM

I, _____ have received or was offered a copy of
(Print Patient's Name)

The Miller Family Dentistry, LLC's, Notice of Privacy Practices.

_____
(Patient's or Guardian's Signature)

PLEASE INDICATE BELOW UNDER BOTH ALL OF THE *NAMES AND RELATIONSHIPS* OF THOSE WITH WHOM WE MAY SPEAK TO REGARDING THE FOLLOWING INFORMATION. (i.e., spouse, parent, child, relative, caregiver etc)

DENTAL TREATMENT _____

_____

_____

_____

ACCOUNT INFORMATION _____

_____

_____

_____

TODAY'S DATE _____