PATIENT REGISTRATION

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience possible.

Date
Patient Name
Preferred Name
Address
City State Zip
Best way to contact you: C W H E-mail Text Message
Cellular Phone No.
Work Phone No.
Home Phone No.
E-mail Address
Birth date **Age** Male □ Female □
Social Security Number
Married □ Child □ Single □ Divorced □ Widowed □
Employer Position
School

Responsible Party
Address
City State Zip
Responsible Social Security No.

DENTAL INSURANCE
PRIMARY DENTAL CARRIER
Insurance Co.
Subscriber Birth date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

SECONDARY DENTAL CARRIER
Insurance Co.
Subscriber Birth date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

The best time for you for appointments are at: _____ AM/PM
The best day of the week is: M T W T F (circle one or more)
Whom may we thank for referring you?
□ Family or Friend's Name
□ Angie's List
□ Website/Internet Search
□ Direct Mail
□ Sign
□ Other
Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designates staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) will be added to my account.

Patient Date

Parent of Guardian Relationship

DENTAL HEALTH HISTORY

Correct Answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Previous Dentist_____ Date of last dental examination_____
Why are you now seeking dental treatment?_____

1. Have you ever had any serious trouble associated with previous dental treatment? Yes No
   If so, please explain_____
2. Does dental treatment make you nervous? No Slightly Moderately Extremely
3. Have you ever had laughing gas ?
   Do you prefer it for some or all dental treatment?_____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth?) Yes No
   If so, when?_____
5. Is there anything you dislike about your smile? Yes No
   If so, please explain_____
6. Do you have or ever had any of the following?

MOUTH

Bleeding, sore gums		
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Dry mouth	Yes	No

ORAL HYGIENE

Do you use the following?		
Toothbrush		
How often do you brush_____	Yes	No
Brush is soft medium hard		
Dental Floss	Yes	No
Waterpik	Yes	No
Fluoride rinse	Yes	No
Other_____	Yes	No

TEETH

Are any teeth replaced with a dental implant?	Yes	No
Loose Teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

JAW JOINT

Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No
Have you ever used a night guard or oral appliance?	Yes	No

MEDICAL HEALTH HISTORY

Patient's name:_____

Primary Physician_____ Telephone No:_____
Date of last physical examination_____

Please answer each question. Circle yes or no. If in doubt, leave blank.

1. Are you in good health now? Yes No
2. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated? _____
   _____
3. Have you been hospitalized or had a serious illness? Yes No
   If yes, please explain_____
   _____
4. Have you ever been diagnosed with sleep apnea? Yes No When?_____
   If yes, do you wear a CPAP? Yes No
   Name of physician treating this condition._____
5. Have you ever had excessive bleeding following an extraction or do cuts take longer to heal now than previously? Yes No
6. Do you use tobacco in any form? If yes, how much_____ Yes No
7. Do you drink alcoholic beverages (more than 2 drinks per day)? Yes No

GENERAL
Tire easily, weakness Yes No
Marked weight changes Yes No
Night sweats Yes No
Persistent fever Yes No

SKIN
Eruptions (rash) hives Yes No
Warts Yes No
Change in skin color Yes No

ENDOCRINE SYSTEM
Diabetes Type_____ Yes No
Thyroid Type_____ Yes No

HEARING
Loss of Hearing Yes No
Ringing in ears Yes No

NOSE
Frequent nosebleeds Yes No
Sinus Problems Yes No

THROAT
Soreness/hoarseness Yes No

NERVOUS SYSTEM
Stroke Yes No
Convulsions/epilepsy Yes No
Numbness/tingling Yes No
Dizziness/fainting Yes No
Psychiatric treatment Yes No

RESPIRATORY
Tuberculosis Yes No
Emphysema Yes No
Epilepsy/Seizures Yes No
Asthma/Hay fever Yes No
Persistent cough Yes No
Sputum production (Phlegm) Yes No
Cough up bloody sputum Yes No
Snoring Yes No

HEART/BLOOD VESSELS
Rheumatic Fever Yes No
Heart Murmur Yes No
MVP Yes No
Heart attack/trouble Yes No
Shortness of breath Yes No
High Blood pressure Yes No
Congenital Heart Disease Yes No
Artificial heart valve Yes No
Pacemaker Yes No
Heart Surgery Yes No
Other_____

BONE/MUSCLES
Arthritis/rheumatism Yes No
Artificial Joint Hip__Knee __ Yes No
Implant, any type _____ Yes No

DIGESTIVE SYSTEM
Hepatitis Type_____ Yes No
Ulcers Yes No
Change in appetite Yes No
Kidney disease Yes No
Venereal Disease Yes No

BLOOD
Bruise easily Yes No
Anemia Yes No
Sickle Cell Disease Yes No
Blood transfusion Yes No
Hemophilia Yes No

OTHER
Radiation & or Chemo therapy Yes No
Cancer Yes No
HIV positive, ARC, Aids Yes No
HPV Yes No
Transplanted Organ_____ Yes No

8. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes	No	Penicillin	Yes	No
Barbiturates/sedatives/sleeping pill	Yes	No	Aspirin or codeine	Yes	No
Epinephrine sensitivity	Yes	No	Sulfa	Yes	No
Latex	Yes	No	Other allergies_____	Yes	No

9. Have you ever been treated with a Bisphosphonate Drug(i.e Fosamax, Zometa, Actonel, Aredia, etc) oral or IV? Yes No
If yes, currently using_____ stopped for how long_____

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Tranquilizers	Yes	No
Blood thinners	Yes	No	Insulin or other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Treatment for drug addiction	Yes	No
Thyroid medication	Yes	No	Recreational drugs	Yes	No
Cortisone/steroids	Yes	No	Digitalis or heart medications	Yes	No
Antihistamines/allergy drugs	Yes	No	Nitroglycerin	Yes	No
Cold remedies	Yes	No	Aspirin	Yes	No
Ginkgo Biloba	Yes	No			

List all medications you are currently taking

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

9._____ 10._____

WOMEN:

Are you pregnant, trying to become pregnant or any chance that you might be pregnant? Yes No
If yes, give due date_____
Are you taking birth control pills? Yes No
Are you breast feeding? Yes No
Are you taking hormone replacement Yes No

I understand the information the information I provide on this form is essential to determine my dental needs and the provision of treatment. I understand that if any change occurs in my health, I must report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability.

Signature of Patient, Parent, or Guardian_____

Please sign and date if there have been no changes in your dental and medical history

1. Patients signature_____ Date _____ Staff initials_____
2. Patient's signature_____ Date _____ Staff initials_____
3. Patient's signature_____ Date_____ Staff initials_____
4. Patient's signature_____ Date _____ Staff initials_____

Dental Insurance: Points to Consider

The following is a plain-language synopsis of most dental insurance contracts. Please read it carefully, and perhaps keep it for future reference.

- ✓ Dental insurance benefits do not work in the same way as medical insurance. There is ***almost always a co-payment*** due from the patient for ***almost every*** procedure.

- ✓ There are "deductibles" in all plans. At one time these deductibles were never taken out of preventive treatment ("cleanings"). Recently many carriers have begun to take deductibles out of preventive treatment.

- ✓ Insurance companies do not typically provide seminars or instruction books on the best method to obtain the highest financial reimbursement benefits for the patient.

- ✓ Irrespective of any dental insurance benefits that might exist, the patient is always legally responsible for the entire cost of dental treatment.

- ✓ The extent of dental coverage is solely dependent on the dental insurance plan purchased by the employer. The higher the premium the employer pays, the greater the dental insurance benefits.

- ✓ Even if there is a written predetermination of benefits returned from the insurance carrier, it is possible that after treatment is provided, there are no insurance benefits payable.

- ✓ We (the dental office) have absolutely no power or leverage to deal with the insurance carrier. Only the employee or the contract purchaser has power. Any complaints about benefits, payment, or coverage should be directed to Human Resources or the company owner.

- ✓ The letters *UCR* on insurance vouchers stand for *Usual, Customary, and Reasonable* fee. The dollar amount you see as UCR has no basis in reality. It is an arbitrary amount determined solely by the plan selected and insurance premium paid by the employee. There is no relationship to the actual dental office fee. The better the plan (i.e., the more premium paid), the higher the UCR will be.

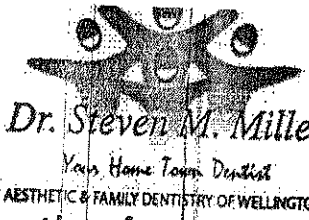
- ✓ A single insurance carrier may have a dozen different UCR fees for the same procedure, same office, and same dentist.

- ✓ There is no universal coverage and payment schedule established. Just because an insurance code describing a dental service exists, it does not guarantee that it will be a paid benefit under your policy. There are many dental procedures that are necessary, and many of them are preventive, but are not covered benefits.

- ✓ Financial benefits cannot be saved and carried over into the next year.

Your dental benefits almost always have a yearly maximum contribution level. This amount is the MOST your insurance carrier is contractually obligated to pay during a defined year (calendar or otherwise). When this amount is reached, there will be no further dental benefits payable until the next benefit year. If you have already begun some additional dental treatment prior to the maximum being reached, the insurance carrier has no payment obligation beyond that of the annual maximum.

Dr. Steven Miller 12788 West Forest Hill Blvd Suite 2001 Wellington, Fl 33414
561-798-8023



Dr. Steven M. Miller

Your Home Town Dentist

AESTHETIC & FAMILY DENTISTRY OF WELLINGTON

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information And Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Telephone Number Home or Cell

Address (Street, City, State, Zip Code)

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my dental information. The people may call and speak with the dentist about my case. I have the right to terminate this agreement at any time by informing a representative of **Aesthetic and Family** Dentistry of Wellington

Authorized Name	Relationship to Patient

*DO NOT discuss or provide information to the following individuals or entities:

Restricted Name/Entity	Relationship to Patient

*I request the use of **ONLY** the following address and/or phone numbers) to contact me regarding my health or billing information:

Patient Rights: Aesthetic and Family Dentistry of Wellington must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosers of protected health information to carry out treatment, payment, and heathcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition. All requests for restrictions must be submitted in writing.

Dental Office Responsibilities: Aesthetic and Family Dentistry of Wellington is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or consent if it is needed to provide that treatment.

Signature of Patient or legal Representative	Date

If Signed by Legal Representative, Relationship to Patient