Welcome to our Practice!

Thank you for selecting our dental healthcare team! We still strive to provide you with the best possible dental care. To help us meet all your dental needs, ***please fill out this form completely****. If you have any questions, please ask us - we will be happy to help.*

Patient Information (CONFIDENTIAL)

*Patients Name*________________________________*Nickname*____________________

First *Middle* *Last*

*Address*____________________*City*________________*State*________*Zip*__________

*Birthdate*________*Age*_______*Birthplace*______________ *Male*___*Female*____*Home Phone* (_____)__________

Name of School/College ______________________________ *Grade*__________

*What are your hobbies?*____________________*What is your favorite subject?*______________

*Do you participate in any activities?(sports, dance, etc.)*______________________________

*What do you want to be when you grow up?*______________*What is your favorite color?*______________

*Name and Ages of Brothers and Sisters*______________________________

	Mother	*Father*
Name		
Social Security #		
Date of Birth		
Employer		
Work Phone #		
Cell Phone/Beeper#		
Email Address		

*Person to Contact in Case of Emergency?*________________________*Phone( )*__________ *Name of*

*Person Responsible for this Account*________________________*Relationship to Patient*______________

*Address*________________________________*Home Phone*(_____)______________

*Social Security #*________________________________*Birthdate*______________

*Employer*________________________________*Work Phone*(_____)______________

*Whom May We Thank For Referring You?*________________________________

Dental History *Circle*

One

1. *Who is your family dentist?*______________________________
2. *Has your child previously seen a dentist?*______________________________
3. *Does your child often exhibit fear, anxiety, or stress, or have difficulty relating to peers, school, church, home or new situations?*______________________________ Yes No
4. Do you expect your child to be overly fearful, anxious, or stressed when receiving dental treatment?______________ Yes No
5. *Has your child had a toothache recently? When?*______________________________ Yes No
6. *Has your child chipped or damaged any of his/her teeth? When?*______________________________ Yes No
7. *Is there a history of oral habits (thumb or finger sucking, lip or nail biting)?*______________________________ Yes No
8. *Does your child's oral hygiene habits (brushing & flossing) need improving?*______________________________ Yes No
9. *Does your child snack frequently?*______________________________ Yes No

*10 Does your child like to "graze" or take a long time when snacking?*____________________ Yes No

*11. Does your child frequently drink beverages other than water?*____________________ Yes No

*12. Does your child drink less than 1 quart of water per day(1 pint 3-6 yrs,1 cup under 3 years)?*__________ Yes No

*13. Does your child drink well water or bottled water?*____________________ Yes No

Patient Medical History

1. Has your child ever experienced any of the following: ***(SPECIFY CONDITION)*** ***Circle One***

a. Seizures, loss of consciousness, fainting, cerebral palsy, trauma to the head or retardation? Yes No

b. Heart disease, rheumatic fever, prolonged bleeding or any blood dyscrasias or disease? Yes No

If heart problem, does your child need an antibiotic for dental procedures? Yes No

c. Shortness of breath, difficulty in breathing, pneumonia or any chronic infection of the respiratory tract:(bronchitis or asthma)? ____________________ Yes No

d. Has your child been diagnosed ADD or ADHD?____________________ Yes No

If so, is your child taking any medication?____________________ Yes No

e. Liver disease, jaundice, or any malabsorption syndrome?____________________ Yes No

f. Kidney or bladder disease?____________________ Yes No

g. Diabetes or glandular problems?____________________ Yes No

h. Allergies or any unfavorable reaction to any medication such as: penicillin, aspirin, or local anesthetic?_ Yes No

2. *Is your child taking any medication at this time? (to include birth control pills or non prescription drugs, etc.)*__________ Yes No

3. *Has your child ever had a serious illness or operation?*____________________ Yes No

4. *Has your child ever been hospitalized? For What?*____________________ Yes No

5. *Has your child had a physical exam within the last year?*____________________ Yes No

6. *Child's Physician or Pediatrician*____________________

*Phone No. & Address*____________________

7. *Is your child:* ______Advanced?______Progressing Normally?______A Slow Learner?______Hyperactive?

8. *Is your child adopted?*____________________ Yes No

9. *Does your child experience anxiety, fear, or stress in new situations, at home, school or physician or dental offices?*____________________ Yes No

10. *Has your child ever had any unfavorable experience in a dental or medical office?*____________________ Yes No

11. *Does your child have difficulty cooperating when receiving an injection(shot) from medical staff?*__________ Yes No

Consent

Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental service can be started. I grant, Dr. Phillip H. Miller, permission to provide my child's dental exam and treatment and I will be responsible for the cost of this dental care including any finance charge(s)(1.5% per month or 18% annual percentage rate), collection fees, attorney fees, and court costs in the event such collection actions become necessary.

Date:____________________ Authorized Signature:____________________

Parent or Guardian

Appointment Policy

It is important to us to have verbal confirmation for all appointments. As a courtesy, my staff will attempt to contact you 1-2 days prior to your appointment for confirmation. However, we do ask that parents assume responsibility for their child's appointed time.

We hope to be able to serve you better by establishing the following guidelines:

- We must, at all times, have all current contact names and numbers.
- Patients may not be seen in the order they arrive due to their unique treatment needs.
- We require 24 hours notice for any change in your appointment. If we have not received a verbal confirmation of your appointment, we reserve the right to cancel your appointment to allow other patients to be seen.
- Broken appointments, short term cancellations (less than 24 hrs notice), or failed appointments (no call, no show) without proper notification can be costly to us and unfair to other patients who could have benefited from your appointment. Please be aware that repeated broken or failed appointments or short term cancellations may be subject to a $25 fee being charged per ½ hour of appointment time missed or even dismissal from the practice. Any failure fees must be paid before another appointment is scheduled.
- Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule, if time allows, or re-appointed to another day. Please try to make contact as soon as possible if you know you will be running late. Repeated late arrivals will be subject to the same guidelines as broken or "failed" appointments.
- During the school months, late afternoon appointments are in high demand. We are able to have more afternoon appointments available by scheduling longer appointments and preschool children during school hours. The morning can provide a better experience for longer appointments and for younger children, as your child will not be as tired by everyday activities. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child. Should you miss or "fail" an after school appointment, we reserve the right to request that you only be seen during our morning hours for a period of time.
- There are occasional needs to change or revise our schedule due to a dental emergency of another patient or due to illness of one of our staff members. We may need to call patients with existing appointments to change their appointment time. Please be aware that if we must change your appointment time and are unable to reach you that we will try to accommodate you as soon as possible on the same day, however, we reserve the right to re-appoint as needed.

We hope to provide your child with a lifetime of happy smiles! By signing below, you are consenting to what is set forth above.

______________________________ Signature

Date ________________________

Authorization for Release of Information

Patient Information:
Name of Patient____Date of Birth__________________
Address____
City, State, Zip____

Name & Address of Covered Entity Authorized to release information:

Augusta Pediatric Dentistry
Phillip H. Miller DMD, P.C.
104 Kings Chapel Road
Augusta, Georgia 30907
(706) 860-2244

The above named entity is authorized to disclose protected health information to the following entity:____
____
____
____

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to: **Dr. Phillip H. Miller DMD, P.C., 104 Kings Chapel Road, Augusta, Georgia 30907.**

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

____ Date__________________________
Signature of Patient or Personal Representative

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written notification to: **Dr. Phillip H. Miller DMD, P.C., 104 Kings Chapel Road, Augusta, Georgia 30907.**

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to: **Dr. Phillip H. Miller DMD, P.C., 104 Kings Chapel Road, Augusta, Georgia 30907.**

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

____ Date_________________________
Signature of Patient or Personal Representative

____
Print or Type Name of Patient or Personal Representative

Description of Personal Representative's Authority

- ▫ Parent

For the following, please show documentation, if available

- ▫ Step-parent
- ▫ Legal Guardian
- ▫ Grandparent

Privacy Notice to Patients

This notice describes how medical/dental information about you may be used and disclosed by Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C., and how you can get access to this information. **Please read it carefully. For all purposes, the term "you" and "your" in our Privacy Notice refers to you and any minor under your care/guardianship.**

Effective Date: April 14, 2003

Under the HIPAA Privacy regulations, Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C. and all similar health care providers are required by federal law to maintain the privacy of your protected health information (PHI) and will abide by the terms in this Privacy Notice.

Please be advised that Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C., may use your PHI in rendering treatment to you. For example, we are permitted to use you PHI in providing you with care/treatment when you visit our office or when we treat you in a hospital facility. Under federal law, we may disclose our PHI to you or we can disclose your PHI to third parties for treatment. For example, if we refer you to a specialist, we will forward your medical information to such specialist. We can disclose your PHI for payment purposes. For example, we will disclose your PHI to your insurance provider, employer, Medicaid or other party responsible for providing you with health/dental insurance coverage. We will also use or disclose your PHI for health care operations. For example, we may use your PHI when we engage in quality assurance and medical chart reviews, which are a part of our health care operations. We may also disclose your PHI, when required by the Secretary of The US Department of Health & Human Services.

Unless disclosure is required under federal, state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your PHI without your authorization. Our practice may use or disclose your PHI in accordance with the specific requirement of the HIPAA rules without Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C. needing to obtain your authorization if the information is:

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect or domestic violence
4. Required by a health oversight agency for oversight activities authorized by law
5. Required in the course of any judicial or administrative proceeding
6. Required for a law enforcement purpose to a law enforcement official
7. Required by a coroner or medical examiner
8. Required by an organ procurement organization for research
9. If disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

Additionally, if you are a member of the armed forces, we are permitted to disclose your PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate mission.

We may also contact you via email or phone to remind you of appointments with our office or to discuss treatment alternatives.

In the event our practice wishes to disclose your PHI to another entity for reasons other than treatment, payment, practice operations, or those referenced above, we are required to obtain your authorization. For example, if we desired to participate in an outside research study, we would need your written authorization prior to releasing your PHI. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C. a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures.

Please be further advised that you have the ability to access, copy, inspect, and amend your medical information that we maintain. You may be subjected to a fee for copy costs for staff involvement. Additionally, if you desire, we can provide you with an accounting of all disclosures for treatment, payment, or healthcare operations and pursuant to authorization.

If you have a dispute with our practice regarding our use of your PHI or an disclosure by Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C. and believe that your primary rights have been violated, please contact our office to file a dispute. You may alternatively contact the Secretary of Health & Human Services.

Lastly, please be advised that you have the right to request restrictions on certain use and disclosures of your PHI to carry out treatment, payment or healthcare operations of disclosures by Augusta Pediatric Dentistry, Dr. Phillip H. Miller D.M.D. P.C. of your PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested restriction. If you request a copy of your PHI, you also have notice as revised. Notices will be posted and provided to you upon your visit.

If you have any questions, please call our office at (706)860-2244.

Please sign below acknowledging receipt of Augusta Pediatric Dentistry's, Dr. Phillip H. Miller D.M.D. P.C. Privacy Notice.

____ ____________________
Signature Date

____
Child's name

Important Dental Insurance Information for our Patients

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turnaround.
3. Researching your dental insurance plan to advise you of benefits available to you.
4. Re-filing your insurance a second time within 30 days.
5. Re-filing your insurance a third time within 60 days.
6. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing that dental insurance policies restrict payment for some services, use restricted fee schedule (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. Keeping our office informed of any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the below space and have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Phillip H. Miller to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Phillip H. Miller. I understand I am responsible for any unpaid balance.

______________________________ **Date:**____________________

Signature of Parent/Insured

____

Name of Patient