NORTH AUSTIN DENTISTRY
TREATING YOU LIKE FAMILY
Dr Logan Miller, DDS PLLC

New Patient Registration Date: _____

Patient Name: _____ M□ F□ Age: _____

Date of Birth: _____ Drivers License #_____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Name & Phone Number of Preferred Pharmacy: _____

How did you hear about our office? _____

Responsible Party *(If the patient is a minor)* _____ Phone: _____

Relationship to the Patient: □ Parent □ Legal Guardian □ Other: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Insurance Information

Name of Policy Holder: _____ Date of Birth_____ □M □F

Name of Insurance: _____ ID#_____ Group #_____

Employer/Group Name: _____ Ins. Phone Number: _____

Insurance Billing Address: _____

Relationship to the Patient: □ Self □ Spouse □ Parent □ Legal Guardian □ Other: _____

Please fill out the rest if the insured individual is not the patient:

Address: _____ City_____ State____ Zip_____

Home Phone: _____ Cell_____ SSN_____

Email Address: _____

MEDICAL AND DENTAL HISTORY

Are you currently under a physician's care? Y□ N□ If yes, please explain: _____
Have you been hospitalized or had major operation? Y□ N□ If yes, please explain: _____
Have you had serious head and neck injury? Y□ N□ If yes, please explain: _____
Are you taking any medication or pills? Y□ N□ If yes, please explain: _____
Are you on a special diet? Y□ N□ If yes, please explain: _____
Do you smoke or use tobacco? Y□ N□ If yes, please explain: _____
Do you use controlled substances? Y□ N□ If yes, please explain: _____

Women: Are you currently pregnant / trying to get pregnant? Y□ N□
Are you currently nursing? Y□ N□
Are your currently taking contraceptives? Y□ N□ If yes, please list _____

Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Local Anesthetics
□ Acrylic □ Metals □ Latex □ Sulfa □ Other:_____

Have you ever been instructed by a physician to take a pre-medication or take any special precautions prior to dental treatment? Y□ N□ If yes, please explain: _____
_____

Please check **Yes** or **No** for any of the following that you have or have had in the past:

AIDS/HIV	Y□ N□	Fainting Spells/Dizziness	Y□ N□	Osteoporosis	Y□ N□
Alzheimer's Disease	Y□ N□	Frequent Cough	Y□ N□	Pain in jaw joints	Y□ N□
Anaphylaxis	Y□ N□	Frequent Diarrhea	Y□ N□	Parathyroid	Y□ N□
Anemia	Y□ N□	Frequent Headaches	Y□ N□	Psychiatric Care	Y□ N□
Angina	Y□ N□	Genital Herpes	Y□ N□	Radiation Treatments	Y□ N□
Arthritis/Gout	Y□ N□	Glaucoma	Y□ N□	Recent Weight Loss	Y□ N□
Artificial Heart Valve	Y□ N□	Hay Fever	Y□ N□	Rheumatic Fever	Y□ N□
Artificial Joint	Y□ N□	Heart Attack/Failure	Y□ N□	Rheumatism	Y□ N□
Asthma	Y□ N□	Heart Murmur	Y□ N□	Scarlet Fever	Y□ N□
Blood Disease	Y□ N□	Heart Pacemaker	Y□ N□	Shingles	Y□ N□
Blood Transfusion	Y□ N□	Heart Trouble/Disease	Y□ N□	Sickle Cell Disease	Y□ N□
Breathing Problem	Y□ N□	Hemophilia	Y□ N□	Sinus Trouble	Y□ N□
Bruise Easily	Y□ N□	Hepatitis A	Y□ N□	Spina Bifida	Y□ N□
Cancer/Chemo	Y□ N□	Hepatitis B or C	Y□ N□	Stomach/Intestinal Disease	Y□ N□
Chest Pains	Y□ N□	Herpes	Y□ N□	Stroke	Y□ N□
Cold Sores/Fever Blisters	Y□ N□	High Blood Pressure	Y□ N□	Swelling of Limbs	Y□ N□
Congenital Heart Disease	Y□ N□	High Cholesterol	Y□ N□	Thyroid Disease	Y□ N□
Convulsions	Y□ N□	Hives or Rash	Y□ N□	Tonsillitis	Y□ N□
Cortisone Medicine	Y□ N□	Hypoglycemia	Y□ N□	Tuberculosis	Y□ N□
Diabetes	Y□ N□	Irregular Heartbeat	Y□ N□	Tumors or Growths	Y□ N□
Drug Addiction	Y□ N□	Kidney Problems	Y□ N□	Ulcers	Y□ N□
Easily Winded	Y□ N□	Leukemia	Y□ N□	Venereal Disease	Y□ N□
Emphysema	Y□ N□	Liver Disease	Y□ N□	Yellow Jaundice	Y□ N□
Epilepsy or Seizures	Y□ N□	Low Blood Pressure	Y□ N□	Other: _____	
Excessive Bleeding	Y□ N□	Lung Disease	Y□ N□	_____	
Excessive Thirst	Y□ N□	Mitral Valve Prolapse	Y□ N□	_____	

Do you have or have you had any other conditions not listed above? □ No □ Yes _____

Are you nervous about dental treatment? □ No □ Yes

Have you even had an upsetting dental experience? □ No □ Yes _____

Please check and of the following that apply to you:

-Sensitivity (hot, cold, sweet) Y□ N□
-Headaches, ear aches, neck aches or jaw joint pain? Y□ N□
-Mouth ulcers or cold sores Y□ N□
-Broken teeth or broken fillings Y□ N□
-Grinding or clenching teeth Y□ N□
-Bleeding, swollen or irritated gums Y□ N□
-Loose, tipped or shifting teeth Y□ N□
When was your last dental visit? _____

The questions on this form have been answered to the best of my ability. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr Miller of any changes to my health and/or medical status.

Patient Signature: _____ Date: _____

GENERAL AND FINANCIAL CONSENT, INSURANCE GUIDELINES

_____I authorize North Austin Dentistry to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

_____ *Drugs and Medication:* I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ *Anesthesia:* I realize the risks in receiving an anesthetic, some of which are upset stomach, dizziness, and vomiting, adverse reaction to drugs causing cardiac arrest, and miscarriage.

_____ *Changes in Treatment Plan:* I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitate procedures different from those originally planned. I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination. I consent to any/all changes and additional procedure(s) which Dr Miller may consider necessary.

_____I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized

_____ I understand the financial obligation attached to this procedure and agree to comply as listed on a separate service agreement, where I understand and acknowledge that I am financially responsible for all fees for the services provided for myself or the above named, regardless of insurance coverage.

_____ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for education purpose, security purposes and/or the practice's healthcare operations purposes.

_____I consent to receive text messages and emails from the practice. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information. Standard text messaging rates may apply; contact your carrier for pricing plans and details.

_____I authorize North Austin Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners, to the extent permitted under applicable law.

_____ I understand that a deposit may be required for some appointments depending on the length of the appointment or amount of treatment to be performed. I will be notified if my appointment requires a deposit, and I agree to comply with the terms as listed on a separate service agreement.

_____ I understand that payment is expected in full at the time of my appointment. If I require financial arrangements, I will inform the front desk staff prior to my scheduled appointment. Any amount due over $300 will be collected before the appointment begins.

_____ I understand that the full responsibility for payment of all fees for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered, regardless of insurance coverage.

_____ I understand that it is imperative that I am aware of my insurance policy coverage, and it is my responsibility to inform the office should there be any changes in my policy.

_____ I understand that despite verifications of eligibility & benefits made by this office prior to my appointment, ***insurance companies never guarantee payment*** for services rendered. If my insurance carrier does not pay, or pays less than my actual bill, I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ I authorize and hereby request my insurance company to pay directly to the dentist, Logan B. Miller, DDS, North Austin Dentistry, insurance benefits otherwise payable to me, for any and all services rendered.

_____ In the event of default, I will be charged for a $30.00 Non-Sufficient Funds Fee for insufficient funds, reasonable attorney's fee and collection cost. I further understand that a monthly billing charge may be added to any balance over 30 days.

_____ I understand that when I schedule an appointment, the time is reserved exclusively for me and that there will be a charge of $50.00 for any appointment failed or rescheduled without 48 hour notice. Further delinquent appointments may result in my dismissal from this practice.

_____ Credits will remain on my account unless otherwise requested. All refunds will be in the form of a check.

_____ I understand that North Austin Dentistry will automatically charge my card for any unpaid balance under $50, and I will be contacted prior to charging the balance. Any balance over $50 will be sent as a statement.

A comprehensive outline of the Financial and Insurance Billing guidelines can be found in the waiting room.

HIPAA ACKNOWLEDGEMENT

_____Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment activities, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the Notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my protected health information for the purposes described in the practices Notice of Privacy Practices.

_____Release of Information

I hereby permit North Austin Dentistry practice, other dental or medical health professionals and insurance companies involved in my dental care to release healthcare information for purposes of care decisions, treatment, payment, or healthcare operations.

_____Disclosures to Friends and/or Family Members

I give permission for my protected health Information to be disclosed for purpose of communicating diagnosis, treatment and care decisions to the family members and other listed below:

Name: _____*Relationship:* _____*Phone:* _____
Name: _____*Relationship:* _____*Phone:* _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, through our website www.northaustindentist.com.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____