

Jennifer J. Miller

DDS

DENTISTRY OF DUBLIN



# New Patient Kit

\_\_\_\_\_  
*Patient Name*

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PATIENT INFORMATION

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City ST ZIP  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Status:  Minor  Single  Married  Divorced  Widowed  Separated  
 Patient or Parent's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Spouse or Parent's Name: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Spouse or Parent's Work Phone: \_\_\_\_\_  
 Referred by? \_\_\_\_\_  
 Person to Contact in Case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

RESPONSIBLE PARTY

Name of Person Responsible for this Account: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City ST ZIP  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Ins. Co. Address: \_\_\_\_\_  
Street City ST ZIP

SECONDARY INSURANCE INFORMATION

Name of Insured: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Name of Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_  
 Ins. Co. Address: \_\_\_\_\_  
Street City ST ZIP

**Consent:** The undersigned hereby authorizes the doctor or qualified personnel to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis for the purpose of dental treatment and care. I also authorize the doctor to perform any and all treatments and therapy and prescribe medications that may be needed for dental care for the patient named above. I further authorize and consent that the doctor may choose and employ such assistance as he/she deems fit. I also understand that the anesthetic agents embodies a certain risk. I understand that the responsibility for payment of dental services provided in this office for myself or my dependents is mine; due and payable at the time of services are rendered, unless an extended payment plan is arranged with the business office. There is a \$35.00 charge for all returned checks. In the event of default, I promise to pay legal interest on the indebtedness, collection costs, and related legal fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To help us meet all your dental healthcare needs, please complete this form. If you have any questions or need assistance, please call us, 614.689.1500, we will be happy to help.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Purpose of initial visit: \_\_\_\_\_

Are you aware of a problem? \_\_\_\_\_

How long since your last dental visit? \_\_\_\_\_

Were dental x-rays taken? \_\_\_\_\_

Previous dentist's name: \_\_\_\_\_

Previous dentist's address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Previous dentist's phone number: \_\_\_\_\_

Are you happy with the appearance of your teeth?  Yes  No  Don't Know

Have you had any complications with previous dental treatment?  Yes  No  Don't Know

If yes, explain: \_\_\_\_\_

1. Do you clench or grind your teeth?  Yes  No  Don't Know

2. Does your jaw click or pop?  Yes  No  Don't Know

3. Have you experienced any pain or soreness in the muscles of your face or around your ear?  Yes  No  Don't Know

4. Do you have frequent headaches, neck aches or shoulder aches?  Yes  No  Don't Know

5. Do you snore?  Yes  No  Don't Know

6. Does food get caught in your teeth?  Yes  No  Don't Know

7. Do your gums bleed or hurt?  Yes  No  Don't Know  
When? \_\_\_\_\_

8. Do you experience dry mouth?  Yes  No  Don't Know

9. Do you feel your breath is offensive at times?  Yes  No  Don't Know

10. Are any of your teeth sensitive to:  Hot  Cold  Sweets  Pressure

Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? Explain: \_\_\_\_\_

In submitting this form, I agree that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To help us meet all your dental healthcare needs, please complete this form. If you have any questions or need assistance, please call us, 614.689.1500, we will be happy to help.

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you under a physician's care now? Yes  No   
 If yes, please explain: \_\_\_\_\_

Have you been hospitalized or had a major operation? Yes  No   
 If yes, please explain: \_\_\_\_\_

Have you had a serious head or neck injury? Yes  No   
 If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, drugs, or vitamins/supplements? Yes  No   
 If yes, please explain: \_\_\_\_\_

Are you on a special diet? Yes  No

Do you use tobacco and/or vapor products? Yes  No

Do you use controlled substances? Yes  No

Have you had the HPV/Gardasil vaccination? Yes  No

Are you interested in Botox, fillers, or reducing TMJ pain? Yes  No

Do you have any sleep concerns? Yes  No

Have you been told you snore? Yes  No

Have you had a sleep study before? Yes  No

**For Women:**

Are you pregnant/trying to get pregnant? Yes  No

Are you taking oral contraceptives? Yes  No

Are you nursing? Yes  No

**Please list all known allergies:**

*Please continue to Page 2 of the Medical History form...*

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Please select any medical conditions that you may presently have or have had.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Pain in Jaw Joints         |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Psychiatric Care           |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Radiation Treatments       |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Recent Weight Loss         |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Sleep Apnea                |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Heart Pacemaker           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Breathing Problem         | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hepatitis B or C          | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hives or Rash             | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hypoglycemia              | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Irregular Heartbeat       |   |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Joint Replacement         |   |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Kidney Problems           |   |
| <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Liver Disease             |   |
| <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Low Blood Pressure        |   |
| <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Lung Disease              |   |
| <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Mitral Valve Prolapse     |   |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Osteoporosis              |   |

Any serious illness not listed above? \_\_\_\_\_

\_\_\_\_\_

In submitting this form, I agree that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

To help us meet all your dental healthcare needs, please read our privacy practices and fill out the form below. If you have any questions or need assistance, please call us, 614.689.1500, we will be happy to help.

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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 health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** *continued on Page 2*

**Public Benefit:**

We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

**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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

**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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

**QUESTIONS AND CONCERNS**

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
  - we made a decision about access to your health information incorrectly,
  - our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
  - we should communicate with you by alternative means or at alternative locations,
- you may contact us using the information listed below. 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.

Name: \_\_\_\_\_

Address:  
Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

# Thank You!



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Thank you for choosing to join the Dentistry of Dublin family. Our mission is to provide comprehensive and personal dental care from a professional team. An important part of our goal is making the fee component of quality dental care easy and manageable for our patients by offering several payment options.

**Payment Options** In addition to cash and check we also accept most major credit cards.



**Please Note**

Dentistry of Dublin requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. For treatment plans requiring more than 2 appointments and over \$500, alternative payment arrangements may be provided.

A fee of **\$35.00** is charged for patients who miss or cancel more than 1 time in a calendar year without a 48-hour notice. Any appointment scheduled longer than 2 hours will result in a **\$50.00** fee charged to the patient. There will be a **\$35** charge for returned checks.

**Insurance**

In order for us to maintain a high level of service to you, we provide the courtesy of submitting your insurance claim on your behalf and supporting you with maximizing your benefits. Policy coverage, changes, and follow up on unpaid claims is your responsibility

**Outstanding Balance Policy**

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a phone call will be made to make payment arrangements. If no resolution can be made, the account will be sent to collections. **Any statements sent with no response from the patient will result in a \$20.00 late fee added.** Please contact our office with any questions. We aim to always help you achieve optimum dental health.

If your insurance company has not made a payment within 60 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.)

**Cancelation Policy**

*Jennifer J. Miller*

DDS

\_\_\_\_\_  
Patient, Parent or Guardian Signature

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

DENTISTRY OF DUBLIN

