Joy M. Miller, D.D.S.

4268 North Oak Trafficway Kansas City, MO 64116

816-452-5800

Patient Information

Name (First) ________________ (M.I.) ____ (Last) _______________ (Preferred) ____________________
Address ____
City _________________________________ State ___________________ Zip ______________________
Date of Birth ___________________ SS# _________________ Sex M ______F _____
Married ____ Single ____ Child ____ E-mail address ____
Phone Home (___) _______________ Work (___) _____________x ____ Cell (___) _________________
Referred by ________________________________ Employer/Occupation ___________________________

Spouse Information

Name (First) ________________________ (M.I.) ____ (Last) _____________________________________
Date of Birth ___________ SS# ______________ Sex M _____ F _____ Employer ____________________
Phone Home (___) _______________ Work (___) ____________x _____ Cell (___) _________________

Parent Information (if patient is a child)

Mother ____ Father ____ Step ____ Other __________
Name (First) ________________________ (M.I.) ____ (Last) _____________________________________
Address ____
City _________________________________ State ___________________ Zip ______________________
Date of Birth ___________________ SS# _________________ Sex M ______ F _____
Phone Home (___) _____________ Work (___) _____________x _____ Cell (___) __________________

Mother ____ Father ____ Step ____ Other __________
Name (First) ________________________ (M.I.) ____ (Last) _____________________________________
Address ____
City _________________________________ State ___________________ Zip ______________________
Date of Birth ___________________ SS# _________________ Sex M ______ F _____
Phone Home (___) _____________ Work (___) _____________x _____ Cell (___) __________________

Primary Dental Insurance

Policy Holder ____ DOB ___________________
Employer ____ Group # ________________________
Insurance Company ____ ID# or SSN __________________

Secondary Dental Insurance

Policy Holder ____ DOB ___________________
Employer ____ Group # ________________________
Insurance Company ____ ID# or SSN __________________

Dental History

Reason for today's visit? ________________________ Name of last Dentist? _________________________

Last cleaning? _________Last x-rays? _________What was done at your last dental visit? _______________

Have you had periodontal (gum) treatments? **Y N** Do you grind or clench your teeth? **Y N**

Do you wear a bite plate or mouth guard? **Y N** Do you chew tobacco or smoke? **Y N**

Are you happy with the appearance of your teeth? **Y N** Do you have dry mouth? **Y N**

WOMEN: (MEDICAL HISTORY)

Are you pregnant? Y N Are you nursing? Y N

Due Date? Taking Birth Control? Y N

Emergency Contact

__________________ ____________________

Name Phone Number

Health History

Physician's Name ____________________________________ Phone (___) ____________________________

Have you had any recent surgeries/hospitalizations? (the past 5 years) ________________________________

Have you ever taken bisphosphonates? (Fosamax, Boniva, Aredia, Zometa) **Y N**

Please check all that apply

Y N
- o o Acid Reflux (GERD)
- o o AIDS/HIV
- o o Anemia
- o o Anxiety/Nervous Problems
- o o Arthritis/Rheumatism
- o o Artificial Joints
- o o Artificial Heart Valves
- o o Asthma
- o o Blood Thinners (Coumadin, Warfarin, Aspirin, Heparin)
- o o Cancer
- o o Chemotherapy
- o o Chemical Dependency
- o o Cold sores/Herpes

Y N
- o o Congenital Heart Disease
- o o Cortisone Treatment
- o o Defibrillator
- o o Diabetes
- o o Emphysema or COPD
- o o Epilepsy or Seizures
- o o Glaucoma
- o o Heart Disease
- o o Heart Murmur
- o o Heart Surgery
- o o Hemophilia
- o o Hepatitis A, B, or C
- o o High Blood Pressure
- o o Hypoglycemia

Y N
- o o Kidney Trouble
- o o Liver Disease
- o o Neurological Disorders
- o o Osteoporosis
- o o Pacemaker
- o o Psychiatric Care
- o o Sickle Cell Disease
- o o Stents
- o o Stroke
- o o Thyroid Problems
- o o Tuberculosis
- o o Tumor
- o o Ulcers

Medications

List medications you are currently taking: ______

____

____

Pharmacy ________________________________

Phone ___________________________________

Allergies

- o Aspirin
- o Penicillin
- o Barbiturates (sleeping pills)
- o Sulfa
- o Codeine
- o Latex
- o Local Anesthetic
- o Other _________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By Signing below, I acknowledge that I have read a copy of Dr. Miller's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. A copy of the Notice is available upon my request. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice.

SIGNATURE: ____ DATE: ________________________

Print Name: ____

Relationship to Patient: Self Mother Father Other: _______________

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for this activities and health care operations that are related to treatment.

Patient's/ Parent's Signature: ____________________________________ Date: ______________________

FINANCIAL AGREEMENT

Payment Options
Payment for services is due at the time treatment is rendered, unless payment and arrangements have been approved in advance. We accept most major credit cards. CareCredit, a GE Money Company, provides patient financing plans. For more information on CareCredit, please inquire with our front desk staff.

Insurance
We will be happy to help you process your insurance claim form. In order to do so, we must have a copy of your insurance card. The portion not covered by insurance is due and payable at the time of service. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is your responsibility to understand what your insurance does and does not cover prior to your visits, as well as your maximum yearly benefit. As a service to you, we can predetermine your dental benefits on large treatment plans. Please keep in mind, that a predetermination is only an estimate, not a guarantee of payment and that all charges are your responsibility. If you have more than one insurance carrier, please advise the dental personnel. We must emphasize that as dental care providers, our relationship is with you, not your insurance company.

Over Due Accounts
We realize that temporary financial hardships may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. Returned checks will be subject to a $30 service charge. If an account becomes delinquent and communication is not attempted on your part, your account will be at risk of being sent to a collection agency.

Cancellation Policy
Our office requires a 24-hour notice for cancellation of appointments. Without reasonable notice our office reserves the right to charge a $50.00 broken appointment fee. Of course, we understand that situations may arise unexpectedly and we will take this into account prior to assessing fees.

Assignment and Release
I assign directly to Dr. Joy M. Miller all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to my insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I acknowledge that payment is due at the time of treatment. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

I have read the above agreement and understand my financial obligations with this office.

Signature: ____Date: ________________