Michael Miller, dds
LAKE OCONEE FAMILY DENTAL

Patient Information

Today's Date: _____ Email Address: _____

Name: _____ Preferred Name: _____ Circle: Male / Female

Marital Status: _____ Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Home / Mailing Address: _____ Apt #: _____ City: _____ State:____ Zip Code: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Employer: _____ Occupation: _____

Neighbor or relative not living with you for emergency contact: _____ Relation: _____

Contact number: _____

Whom may we thank for referring you?_____ Other family members seeing Dr. Miller?_____

Spouse or Responsible Party Information

Name: _____ Preferred Name: _____ Circle: Male / Female

Relation: _____ Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Home / Mailing Address: _____ Apt #: _____ City: _____ State:_____

Best Contact number: _____

Dental Insurance Information

Primary

Insurance company name: _____ Phone: _____

Name of Subscriber: _____ Subscriber ID #:_____ Group #:_____

Subscriber's Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Patient's relationship to subscriber: circle one - Self / Spouse / Child / Other

Insurance company mailing address:_____

Secondary

Insurance company name: _____ Phone: _____

Subscriber: _____ Subscriber ID #:_____ Group #:_____

Subscriber's Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Patient's relationship to subscriber: circle one - Self / Spouse / Child / Other

Insurance company mailing address:_____

Dental Evaluation

Do you require antibiotics (pre-med) before dental treatment? YES / NO

If yes, Name of antibiotic :_____ Reasoning of pre-med? _____

Why have you come to the dentist today? _____ How long since your last dental visit? _____

What are your primary dental concerns? _____

Have you ever been told that you have periodontal disease? YES / NO Have you had periodontal surgery? YES / NO

Have you been diagnosed with TMJ? YES / NO Do you have any sensitivity or mobility? _____

Have you ever experienced complications with dental treatment? YES / NO If yes, please explain: _____

Are you satisfied with your smile? YES / NO Have you ever considered cosmetic dentistry? YES / NO

What changes would you like to see with your dental health / smile? _____

Previous Dentist's Name: _____ City: _____ State: _____

Medical History

Are you currently under the care of a physician? YES / NO Your current physical health is: Good / Fair / Poor

Primary Doctor's Name: _____ Phone: _____ Last Visit: _____

Address: _____

Do you smoke or use any tobacco products? YES / NO

Are you allergic to any of the following? Please mark all that apply:

- □ Aspirin
- □ Latex
- □ Barbiturates
- □ Penicillin
- □ Codeine
- □ Sedatives
- □ Dental Anesthetics
- □ Sulfa Drugs
- □ Milk / Dairy
- □ Tetracycline
- □ Erythromycin
- □ Jewelry / Metals
- □ Amoxicillin
- □ Clindamycin
- □ Other: _____

Please list any other drugs / materials that cause allergic reactions: _____

Are you currently taking any of the following? Please mark all that apply:

- □ Antibiotics
- □ Antihistamines
- □ Aspirin
- □ Blood thinners
- □ Blood Pressure Meds
- □ Heart Meds / Digitalis
- □ Insulin / Diabetes Meds
- □ Nitroglycerin
- □ Recreational Drugs
- □ Steroids
- □ Thyroid Meds
- □ Other: _____

For women: Are you taking birth control pills / other form? YES / NO Are you pregnant? YES / NO

Do you have or have you ever had any of the following? Please mark all that apply:

- □ Abnormal Bleeding
- □ Alcohol Abuse
- □ Anemia
- □ Arthritis
- □ Artificial Bones / Joints
- □ Artificial Valves
- □ Asthma
- □ Blood Transfusion
- □ Cancer
- □ Chemotherapy
- □ Chicken Pox
- □ Colitis
- □ Congenital Heart Defect
- □ Diabetes
- □ Difficulty Breathing
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy
- □ Fainting Spells
- □ Fever Blisters
- □ Hay Fever
- □ Headaches / Migraines
- □ Heart Attack
- □ Heart Murmur
- □ Heart Surgery
- □ Hemophilia
- □ Hepatitis
- □ Herpes
- □ High Blood Pressure
- □ HIV + / AIDS
- □ Kidney Problems
- □ Liver Disease
- □ Low Blood Pressure
- □ Lupus
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Persistent Cough
- □ Psychiatric Problems
- □ Radiation Treatment
- □ Scarlet Fever
- □ Seizures
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Steroid Therapy
- □ Stroke
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis (TB)
- □ Ulcers
- □ Venereal Disease
- □ Other: _____

Financial Policy and Authorizations

To the best of my knowledge, I affirm that all of the preceding answers and information provided are true and correct. It will be held in the strictest confidence and it is my responsibility to inform Dr. Miller and his office of any changes in my medical or dental status without fail. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____

Signature of patient, parent or guardian Date

Payment is due at the time of service

I certify that I am covered by _____ Insurance Company. I assign directly to Dr. Michael L. Miller and his staff to process all insurance benefits, otherwise they are payable to me. I understand that I am responsible for payment of the services rendered, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the office of Dr. Michael L. Miller and his staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of patient, parent or guardian Date

Thank you for choosing Dr. Michael L. Miller as your dental provider. We welcome you and your family to Lake Oconee Family Dental. We look forward to providing you with excellent dental care.

In an effort to make the cost of dental treatment more manageable, we do process most dental insurances, as well as offer third party financing. However, it is ultimately the responsibility of the patient to verify their own benefits and coverage information and file claims for completed services. As a courtesy, we will be happy to do this for you. Please make us aware of any changes as soon as you are aware of them, and we will update your records.

***** PLEASE be aware that insurance companies will NOT guarantee any coverage until services have been performed and a claim has been filed. *****

Because insurance companies will not guarantee coverage until a claim has been submitted, when we review treatment plans with you for any necessary procedures, we have to make our best educated guess on what your insurance company will cover. (The "allowed" fees, how much they will pay and what your out of pocket portion will be). You will receive an Explanation of Benefits from your insurance company that will detail all payment information by them and what is expected of you. For major services, we are willing to submit a pre-authorization, but only when requested.

It is the patient's (or responsible party's) responsibility to pay for services at the time they are rendered, even with dental coverage. As a courtesy, we will allow patients to pay just the estimated co-payment amount at the time of services and once the claim payment is made and processed by the insurance company, we will either collect the additional portion or issue a refund for any patient overpayment. Claims are submitted promptly after treatment is rendered and if the services are unpaid by your insurance carrier within 60 days of treatment, the patient will be billed for any unpaid balance. Any long-standing balances are subject to the accrual of late fees and finance charges.

Payment Options: Cash / Debit Card / Credit Card / Check / Care Credit

I understand that there will be a minimum of a $50.00 cancellation fee applied to my account if my appointment is cancelled with less than a 24-hour business day notice.

By signing below, I fully understand that I am financially responsible for all charges incurred.

_____ _____ _____

Print Patient Name Signature of Responsible Party Date

Medical Information Release Form
(HIPPA Release Form)

Name of patient :_____ Date of Birth: _____ - _____ - _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be discussed and released to:

[ ] Spouse: Name: _____ Contact Number: _____

[ ] Child(ren): Name: _____Contact Number: _____

[ ] Other: Name:_____ Relationship:_____ Contact Number: _____

[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

_____ _____

Signature of patient, parent or guardian Date

Michael Miller, dds
LAKE OCONEE FAMILY DENTAL

1050 FOUNDERS ROW
GREENSBORO, GEORGIA 30642

PHONE 706.454.3040
FAX 706. 454.3070

Records Release Form

Date: _____

To: _____
Previous Dentist / Doctor / Physician

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Please email records to: service@lakeoconeefamilydental.com

_____ _____
Print name of patient Date of Birth

_____
Signature of patient, parent or guardian