Drs. Love
& Miller, P.C.

Patient Registration

Please Complete the Following Confidential Information

1 IF APPOINTMENT IS FOR *YOU*, START HERE

Date

Last Name First M.I.

Prefers to be Called By

Address

City State Zip

Phone Fax

Mobile Email

Birth Date Age ❒ Male ❒ Female

❒ Married ❒ Single ❒ Divorced ❒ Widowed

Social Security No.

IF APPOINTMENT IS FOR *YOUR CHILD*, START HERE

Date

Last Name First M.I.

Address

City State Zip

Phone

Birth Date Age ❒ Male ❒ Female

School Grade

Social Security No.

If Your Child's Last Name and/or Address are Not the Same as Yours, Fill in the Top Box Also

2 DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No

SECONDARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No.

3 GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?

Name

Relationship

You were referred to us by

Your former address

City State Zip

Person to contact for emergency

Phone

Address

City State Zip

Closest relative not living with you

Phone

Address

City State Zip

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Relationship to Patient

Social Security No.

Address

City State Zip

Phone

YOU

Name

Occupation

Employer's Name

Address City

Phone Fax

YOUR SPOUSE

Name

Occupation

Employer's Name

Address City

Phone Fax

Drs. Love
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Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can inquire about possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made, and that I will be responsible for costs and attorneys fees if this is sent to collection.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible
Party's Signature _____ Relationship to Patient2

Drs. Love
& Miller, P.C.

Medical History

Patient Name		Today's Date	
Patient Account No.		Medical Alert	

	Yes	No
1. **Have you been under the care of a medical doctor during the past two years?**	❒	❒
If yes, for what? _____		
Physician's name _____ Phone _____		
Address _____ City _____ State _____ Zip _____		
2. **Have you taken any medication or drugs during the past two years?**	❒	❒
3. **Are you taking any medication, drugs or pills now, including regular dosages of aspirin?**	❒	❒
If yes, please list name and dosage: _____		
4. **Have you ever taken prescription medications for weight loss (diet pills)?**	❒	❒
If yes, did you take any of the following: Fen-Phen (Fenfluramine-Phentermine)	❒	❒
Pondimen (Fenfluramine)	❒	❒
Redux (Dexfenfluramine)	❒	❒
If yes to any of the above, did you have a medical exam for heart issues?	❒	❒
5. **Are you aware of having an allergic (or adverse) reaction to any medication or substance?**	❒	❒
If yes, please list: _____		
6. **Have you been a patient in the hospital during the past five years?**	❒	❒

7. **Indicate which of the following you have had, or have at present. Check "yes" or "no".**

	Yes	No		Yes	No		Yes	No
Heart (Surgery, Disease, Attack)	❒	❒	Ulcers	❒	❒	Hepatitis A (infectious) B (serum)	❒	❒
Chest Pain	❒	❒	Diabetes	❒	❒	Venereal Disease	❒	❒
Congenital Heart Disease	❒	❒	Thyroid Problems	❒	❒	A.I.D.S	❒	❒
Heart Murmur	❒	❒	Glaucoma	❒	❒	H.I.V. Positive	❒	❒
High Blood Pressure	❒	❒	Contact lenses	❒	❒	Cold Sores/Fever Blisters	❒	❒
Mitral Valve Prolapse	❒	❒	Emphysema	❒	❒	Blood Transfusion	❒	❒
Artificial Heart Valve	❒	❒	Chronic Cough	❒	❒	Hemophilia	❒	❒
Heart Pacemaker	❒	❒	Tuberculosis	❒	❒	Sickle Cell Disease	❒	❒
Rheumatic Fever	❒	❒	Asthma	❒	❒	Bruise Easily	❒	❒
Arthritis/Rheumatism	❒	❒	Hay Fever	❒	❒	Liver Disease	❒	❒
Cortisone Medicine	❒	❒	Latex Sensitivity	❒	❒	Yellow Jaundice	❒	❒
Swollen Ankles	❒	❒	Allergies or Hives	❒	❒	Neurological Disorders	❒	❒
Stroke	❒	❒	Sinus Trouble	❒	❒	Epilepsy or Seizures	❒	❒
Diet (Special/Restricted)	❒	❒	Radiation Therapy	❒	❒	Fainting or Dizzy Spells	❒	❒
Artificial Joints (hip, knee, etc.)	❒	❒	Chemotherapy	❒	❒	Nervous/Anxious	❒	❒
Kidney Trouble	❒	❒	Tumors	❒	❒	Psychiatric/Psychological Care	❒	❒

	Yes	No
8. **Do you use more than two pillows to sleep?**	❒	❒
9. **Have you lost or gained more than 10 pounds in the past year?**	❒	❒
10. **Do you have or have you had any disease, condition, or problem not listed?**	❒	❒
If yes, please list: _____		

11. **Are you pregnant?** ❒ Yes, ___Months ❒ No | **Nursing?** ❒ Yes ❒ No | **Taking birth control pills?** ❒ Yes ❒ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

Drs. Love
& Miller, P.C.

Dental History

Patient Name		Today's Date	
Patient Account No.		Medical Alert	

__Welcome!__ So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

1. **What is the reason for your visit today?** _____

2. **What was done at your last dental visit?** _____

   Date of last dental visit _____ Last dental cleaning _____ Last x-rays _____

   Previous dentist's name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

3. **How often do you have dental examinations?** _____

   How often do you brush your teeth? _____ How often do you floss? _____

   What other dental aids do you use? (Interplak, toothpick, etc.) _____

4. **Do you have any dental problems now?** ❒ Yes ❒ No

   If yes, please describe: _____

Check "yes" or "no".	Yes	No
Are any of your teeth sensitive to:		
Hot or cold?	❒	❒
Sweets?	❒	❒
Biting or Chewing?	❒	❒
Have you noticed any mouth odors or bad tastes?	❒	❒
Do you frequently get cold sores, blisters or any other oral lesions?	❒	❒
Do your gums bleed or hurt?	❒	❒
Have your parents experienced gum disease or tooth loss?	❒	❒
Have you noticed any loose teeth or change in your bite?	❒	❒
Does food tend to become caught in between your teeth? If yes, where?	❒	❒
Do you:		
Hold foreign objects with your teeth? (pencils, pipes, pins, nails, fingernails)	❒	❒
Clench or grind your teeth while awake or asleep?	❒	❒
Bite your lips or cheeks regularly?	❒	❒
Mouth breathe while awake or asleep?	❒	❒
Have tired jaws, especially in the morning?	❒	❒
Smoke/chew tobacco?	❒	❒

	Yes	No
Have you experienced:		
Clicking or popping of the jaw?	❒	❒
Difficulty in opening or closing the mouth?	❒	❒
Difficulty in chewing on either side of the mouth?	❒	❒
Pain? (joint, ear, side of face)	❒	❒
Headaches, neckaches or shoulder aches?	❒	❒
Sore muscles (neck, shoulders)?	❒	❒
Have you ever had:		
Orthodontic treatment?	❒	❒
Oral Surgery?	❒	❒
Periodontal treatment?	❒	❒
Your teeth ground or the bite adjusted?	❒	❒
A bite plate or mouth guard?	❒	❒
A serious injury to the mouth or head? If so, please describe, including cause:	❒	❒

5. **Are you satisfied with your teeths appearance?** ❒ Yes ❒ No

6. **Would you like to keep all of your teeth all of your life?** ❒ Yes ❒ No

7. **Do you feel nervous about having dental treatment?** ❒ Yes ❒ No

   If so, what is your biggest concern? _____

8. **Have you ever had an upsetting dental experience?** ❒ Yes ❒ No

   If yes, please describe: _____

9. **Is there anything else about having dental treatment that you would like us to know?** ❒ Yes ❒ No

   If yes, please describe: _____

Drs. Love
& Miller, P.C.

Statement of Office Policy

In our continued commitment to provide the highest quality of dental health care available to all our patients and to have those services comfortable and affordable, we have made certain changes in our policy that will create the maximum flexibility for each of our patient's individual needs.

1. **AS SERVICES ARE RENDERED**
   For those patients desiring to pay cash or check at the time of visit, we will continue to offer you a 5% discount for payment on all services of $200.00 or more.

2. **CREDIT CARDS**
   We accept Master Card and Visa as payment when services are rendered with a 3% discount for amounts over $200.00.

3. **INSURANCE BENEFITS**
   Please review our office policy regarding your insurance benefits on the reverse side of this form.

We honor our senior citizens with a 5% discount.

CARE CREDIT will provide you, upon approval, with a dental line of credit that is similar to using your Master Card or Visa, but with these added benefits:

1. **NO INTEREST PAYMENT PLAN**
   Requires monthly payment of only 3% of your balance or $20 (whichever is greater) and allows you to avoid paying any interest charges if you pay your balance in full within the 12 months period. If not paid on time, interest rates are 24.23%. Offers 3, 6, 12 months interest free plan.

2. **EXTENDED PAYMENT PLAN**
   For patient with treatment fees from $2,500 to $25,000, who would appreciate more time to pay, the **EXTENDED PAYMENT PLAN** offers a low interest rate and low monthly payment. Interest rates for the extended plan are 12.96%.

3. Pay for immediate treatment with low monthly payment, no upfront costs or annual fees, no prepayment penalty, quick and easy application process.

We now find it necessary to institute changes in our office policies. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible dental care.

Late Policy: If you are more than 15 minutes late for your appointment, we will make every effort to fit you into the schedule. Otherwise, we will have to reschedule your appointment and a missed appointment fee may be incurred. Please remember to bring your insurance card with you so that you may receive proper reimbursement.

Missed Appointment: $50. Missed appointments are appointments cancelled with less than 48 hours notice. Multiple missed appointments may result in your dismissal as a patient.

Dental Records: To obtain copies of your medical records, you must sign a Dental Release form. Please allow one to two weeks for processing records.

Date_____ Patient Signature _____

Drs. Love
& Miller, P.C.

Insurance Information

We are happy that you have the benefit of dental insurance to help maintain excellent oral health. As a **COURTESY** to our patients, we will be pleased to submit that proper information to your insurance company to aid you with acquiring your dental benefits. To accomplish this, we must have insurance forms and completed information provided at the time of the appointment. If information or forms are not provided, your account will be treated as an open account and payment will be due in full at the time of the appointment. We will need a signature on file to be able to send out the insurance claims.

In order to cover deductible expenses and differences in benefits the following payments are expected:

Preventive and Restorative Treatments:

Thirty percent of the total charge is due at the time of the appointment.

Major Restorative: Crowns, Inlays, Bridge, Veneers, and Dentures:

Fifty percent of the total charge and deductible is due at the time of the appointment. **With all insurance coverage, the patient is responsible for balances remaining after our office has received insurance payments. If your insurance has not paid your balance within 45 days, the balance will be due in full upon notification.**

The contractual liability in our office is with the patient, with the patient being responsible for their account.

It is our pleasure to serve your dental needs and thank you for your confidence.

Patient_____ Date _____

Insured _____ Date _____

Melanie R. Love, DDS
Mark A. Miller, DDS

Drs. Love
& Miller, P.C.

Your Child's Medical History

Your Child's Name		Nickname	
Today's Date		Birth Date	
Patient Account No.		Medical Alert	

	Yes	No
1. **Your child's physician name** _____ Phone _____		
Address _____ City _____ State _____ Zip _____		
2. **Is your child under the care of a physician?**	❒	❒
If yes, please describe: _____		
3. **Is your child taking any medications? (prescription or over-the-counter)**	❒	❒
If yes, please describe: _____		
4. **Have you ever been told your child needs antibiotics or premeds before treatment?**	❒	❒
5. **Does your child have any allergic (or adverse) reaction to any medication or other substance?**	❒	❒
If yes, please list: _____		
6. **Are your child's immunizations current?**	❒	❒

List any hospitalizations, surgeries, serious illnesses — **When?**

_____ _____

_____ _____

_____ _____

7. **Indicate which of the conditions your child has now or ever has had. Check "yes" or "no".**

	Yes	No		Yes	No		Yes	No
Abnormal bleeding	❒	❒	Diabetes	❒	❒	Latex sensitivity	❒	❒
AIDS/HIV positive	❒	❒	Epilepsy	❒	❒	Measles	❒	❒
Allergies or hives	❒	❒	Handicaps/disabilities	❒	❒	Mononucleosis	❒	❒
Anemia	❒	❒	Hay fever	❒	❒	Mumps	❒	❒
Asthma	❒	❒	Hearing problems	❒	❒	Neurological disorders	❒	❒
Cancer	❒	❒	Heart murmur	❒	❒	Psychiatric/psychological	❒	❒
Chicken pox	❒	❒	Hemophilia	❒	❒	Rheumatic/scarlet fever	❒	❒
Congenital heart disease	❒	❒	Hepatitis	❒	❒	Stomach problems	❒	❒
Convulsions	❒	❒	Kidney/liver problems	❒	❒	Tuberculosis	❒	❒
Other?	❒	❒	If yes, please list:					

_____

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Patient/Guardian Signature _____ Date _____

Drs. Love
& Miller, P.C.

Your Child's Dental History and Habits

Your Child's Name		Nickname	
Today's Date		Birth Date	
Patient Account No.		Medical Alert	

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

Yes No

1. **What is the reason for your visit today?** _____

2. **What was done at your child's last dental visit?** _____

Date of last dental visit_____ Last dental cleaning _____ Last x-rays_____

Your child's previous dentist name _____ Phone _____

Address_____ City_____ State_____ Zip_____

How often does your child brush?_____ Floss?_____ Do you assist? _____ ❒ ❒

Is your child's water fluoridated? ❒ ❒

Does your child take fluoride supplements? ❒ ❒

3. **Does your child have any dental problems now?** ❒ ❒

If yes, please describe:_____

4. **Has your child had difficulty with previous dental visits?** ❒ ❒

If yes, please describe:_____

5. **Has your child complained about dental problems?** ❒ ❒

If yes, please describe:_____

6. **Has your child ever worn orthodontic appliances?** ❒ ❒

If yes, please describe:_____

7. **Are your child's teeth sensitive to:**

Hot or cold? ❒ Yes ❒ No | Sweets? ❒ Yes ❒ No | Biting or Chewing? ❒ Yes ❒ No

8. **Does your child engage in any of the following? Check "yes" or "no".**

	Yes	No		Yes	No
Sucking thumb or fingers?	❒	❒	Chewing or biting fingernails?	❒	❒
Biting or sucking lips or cheeks?	❒	❒	Chewing hard objects (e.g., pencils)?	❒	❒
Grinding teeth?	❒	❒	Clenching jaw?	❒	❒
Mouth breathing?	❒	❒	Nursing bottle or pacifier habits?	❒	❒

10. **Do your child's gums bleed or hurt?** ❒ ❒

11. **Does your child have any pain or tenderness in the jaw joint, ear side of face?** ❒ ❒

12. **Do you have any special concerns about your child's dental health?** ❒ ❒

If yes, please describe:_____

Drs. Love
& Miller, P.C.

450 West Broad St. Suite 440
Falls Church, Virginia 22046
703.241.2911

Statement of Privacy Practices

We, at Drs. Love and Miller, PC, are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information
We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the cofidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collected Protected Health Information
We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights
You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at Drs. Love and Miller, PC. Please let us know if you have questions concerning your privacy rights and the protection of your personal health information.

Drs. Love and Miller, PC

Drs. Love
& Miller, P.C.

450 West Broad St. Suite 440
Falls Church, Virginia 22046
703.241.2911

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Drs. Love and Miller, PC. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The notice of Privacy Practices is also posted in the facility.

Drs. Love and Miller, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY	
In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.	
Any member of my immediate family	❒ Yes ❒ No
Spouse only	❒ Yes ❒ No
Other (please specify)	❒ Yes ❒ No

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED	
Provided prior to treatment?	❒ Yes ❒ No
Date provided:	
Reason for denial:	
❒ Needed more time to review notice of privacy practices	❒ Wanted to consult with another person
❒ Unable to sign	❒ Reason not given
❒ Other (Explain)	