



LAWRENCE S. MILLER, DMD, PC
Board Certified

Dear Patient:

Welcome to our office. We share in the importance you place on your dental health and hope to make your first visit informative and as pleasant as possible. Your initial visit will take approximately 45 minutes. To facilitate being seen as soon as possible at the time of your appointment, we would appreciate if you would complete the forms before your arrival. Please remember to bring it with you at the time of your appointment or mail the completed forms back to us as soon as possible.

We provide professional services for the diagnosis and treatment of periodontal (gum and bone) disease, cosmetic gum treatment, and dental implants. Your initial examination requires a general health history, complete dental history, and comprehensive examination. In order to make a diagnosis, a recent and complete set of x-rays may be required. If these are not available through your General Dentist they will be taken during your first appointment. In the case of dental implants, special x-rays will be taken. From this information, Dr. Miller will explain your treatment alternatives and you and he will determine the appropriate course of action.

There is a fee for this appointment. If you have dental insurance, please bring the information with you and we will gladly assist you in processing your insurance claim. Prior to your appointment, we suggest that you research your plans policies and limitations. Our office hours are Monday through Thursday from 8am to 5pm.

Please know that we are here to provide the services that will guide you toward dental health.

Sincerely,

Dr. Lawrence S. Miller, DMD & Staff

Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us — we will be happy to help.

PATIENT INFORMATION

Today's Date: _____ Date of Birth: _____
Name: _____ Home Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Social Security #: _____
Employer: _____ Work Phone: _____
Employer's Address: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____
Address: _____ Phone: _____
In case of emergency, contact: _____
Address: _____ Phone: _____
Who referred you to our office? _____
Have we treated any of your family or friends? Yes No Who? _____

MEDICAL HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors, and successful treatment depends upon their identification. The following questions are pertinent to the treatment of your periodontal condition. Please answer all questions. All answers are confidential.

- How is your general health? _____
- Date of last physical: _____ Reason for last exam: _____
- Physician's name: _____
- Are you being treated by a physician or a psychiatrist now? _____
- Have you ever been hospitalized or seriously ill? _____
If yes, please explain: _____
- Are you taking any drugs or medications? If yes, please check the appropriate boxes:
 antibiotics anticoagulants (blood thinners) tranquilizers insulin
 hormones blood pressure medications aspirin cortisone (steroids)
 heart medicine birth control pills other: _____
- Have you ever had a serious infectious disease? Yes No
 Hepatitis Tuberculosis Syphilis Other: _____
- Do you have or have you had any of the following?
 rheumatic heart condition chest pains on exertion frequent headaches x-ray therapy
 heart palpitations low blood pressure fainting or dizziness depression
 high blood pressure shortness of breath cancer cough/cold
 heart murmur diabetes liver problems kidney problems
 epilepsy stroke arthritis ulcer
 lung problems glaucoma AIDS/ARC Other: _____
- Have you noticed any swollen glands or nodes? Yes No
- Have you had abnormal bleeding associated with extractions, surgery, or menstruation? Yes No
- Do you have any implants such as heart valve or hip replacement? Yes No

PLEASE COMPLETE OTHER SIDE

12. Are you allergic to or have you experienced an unusual reaction to any drugs? Yes No
 dental anesthetics penicillin codeine aspirin
 sulfa drugs tetracycline erythromycin other antibiotics
 sedatives or barbiturates Other: _____
13. Do you have any allergic conditions? Yes No
 asthma skin rashes, hives, hay fever sinus problems latex
14. Do you smoke? Yes No If yes, how much? _____ pack(s) per day For how long? _____ years
15. Do you drink alcoholic beverages? Yes No
16. Have you ever had an alcohol or drug problem? Yes No
17. Is there a tendency towards any illness in your family? diabetes heart trouble high blood pressure
18. Do you have any disease, condition or problem not listed that I should know about? Yes No
 If yes, please describe: _____
19. Women: Are you pregnant? Yes No If yes, when is your expected due date? _____

DENTAL HISTORY

1. Are you aware of any problems with the gum or bone around your teeth? Yes No
 What? _____
2. Who is your regular dentist? _____
3. Has your dental care been: Regular Intermittent (when necessary) Infrequent (when in pain)
 Approximate date of your last dental visit: _____
4. How many times have you had your teeth cleaned in the last five years? _____ Last time? ____/____/____
5. Have you ever had periodontal care? Yes No When? _____ Orthodontic care? Yes No
6. Did your mother, father, brother, or sister lose all of their natural teeth? _____ Which? _____
7. Would you be very disturbed if you had to lose your teeth and wear false teeth? Yes No
8. Are you dissatisfied with the appearance of your teeth? Yes No
9. How often do you brush your teeth? _____ Floss your teeth? _____
10. Have you ever experienced any of the following:
 bleeding gums pus around the teeth spaces between teeth swelling of gums
 loose teeth bad breath or taste high or rough fillings food packing between teeth
 receding of gums drifting of teeth Other: _____
11. Do you often have fever blisters on your lips? Yes No After dental work? Yes No
12. Is there sensitivity in your teeth? Yes No
13. Have you ever had an injury to or suffer from pain in your face, neck, or jaws? Yes No
14. Are you aware of grinding your teeth? Yes No Do you clench your teeth? Yes No
15. Did you ever have a bad experience in a dental office? Yes No
16. Is there anything that concerns you about dental treatment? Yes No

These statements are true and complete to the best of my knowledge.

X

Signature of patient or parent if minor

Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option you prefer.

- Cash Personal Check Visa MasterCard I wish to discuss the dental office's policy.

LATE PAYMENTS: The office will provide only emergency dental services for those accounts which fail to remain current. Additional services will be performed only when appointments are paid for in advance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X

Signature of patient or parent if minor

Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask — we are always happy to help.

Lawrence S. Miller, D.M.D , PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient name: _____

To The Patient:

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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available. We encourage you to read it carefully and completely before signing this Consent. 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 of our notice, at any time by contacting:

Contact Person: Dr. Lawrence S. Miller
Telephone #: 978-750-8828 Fax: 978-750-8805

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 use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I am entitled to a copy of this consent after I sign it and will request it if desired.

Signature _____ Date: _____

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DENTAL INSURANCE INFORMATION

SUBSCRIBER INFORMATION:

Name of Insured: _____
Relationship to patient: _____
Insured birthdate: _____ Social Security # _____
Employer: _____ Date Employed: _____
Occupation: _____
Insurance Company: _____
Group# _____ Employee/Cert# _____
Insurance Co. Address: _____

ADDITIONAL DENTAL INSURANCE

Name of Insured: _____
Relationship to patient: _____
Insured Birthdate: _____ Social Security# _____
Employer: _____ Date Employed _____
Occupation: _____
Insurance Company: _____
Group# _____ Employee/Cert # _____
Insurance Co. Address: _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and /or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services I agree to be responsible for payment of all the services rendered on my behalf or my dependents.

X _____
Signature of Patient **Date**