THANK YOU FOR COMING TO SEE US TODAY – PLEASE LET US KNOW IF WE CAN BE OF ANY HELP AS YOU PROVIDE THE FOLLOWING INFORMATION

Patient Information

Today's Date_____/_____/_____

Name: ____ ☐M ☐F
Last First MI Preferred- Nickname

Birthdate:______/______/_______ Age:________ SS#:______________________ DL#:____________________

Home Address:____
City State Zip

Hm#:(______)_____________ Cell #:(______)_____________ Wk#(______)_____________ E-mail:________________________

Spouse's Name:______________________________________ Spouse's Cell # (____)__________Wk# (____)___________
Last First

Dentist Name:______________________________________ Dentist Phone #: (____)___________Date of last visit____/____/____

Dentist Address ______________________________________
City State Zip

Whom may we thank for referring you to our office?______________________________________

Other family members seen by us?______________________________________

What are your main concerns today?______________________________________

Is there anything else we need to know about you?______________________________________

How would you describe your current physical health?______________________________________

Are you allergic to any medications, metals, or latex?______________________________________

Do you use any form of tobacco?______________________________________

Are you currently taking any medications?______________________________________

Are you currently under the care of a physician?______________________________________

For women-Are you pregnant or do you suspect that you may be pregnant? ☐YES ☐NO

Do you require pre-medication for dental visits? ☐YES ☐NO ☐ I'M NOT SURE

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Arthritis	Y N	Liver Disease/Hepatitis	Y N	Heart Defect/Murmur	Y N	Cancer/Cancer Treatment	Y N	Mouthbreathing	Y N	Headaches	Y N
Asthma	Y N	Compromised Immunity	Y N	Heart Disease/Attack	Y N	Difficulty Breathing	Y N	Bleeding Disorders	Y N	Snoring	Y N
Diabetes	Y N	Hypertension/Stroke	Y N	Prolonged Thumb Sucker	Y N	Rheumatic/Scarlet Fever	Y N	Difficulty Breathing	Y N	Tonsillectomy	Y N

Please list any serious medical conditions that you have experienced? ______________________________________

I affirm that the information I have given above is correct to the best of my knowledge. I will be financially responsible for this account. I understand that it is my responsibility to inform this office of any changes in my child's medical/dental condition.

Signature Date
____

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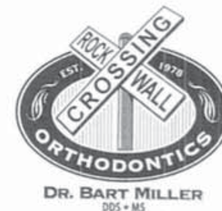

Primary Insurance

Who is primary insured party (check one) ☐ Patient ☐ Mother ☐ Father
☐ Other ________________

Insurance Company Name:	Insured's Name: First, Middle, Last
Insurance Company Address:	Insured's Address: City, State, Zip
Insurance Company City, State, Zip	Insured's Date of Birth Insured's Sex (M or F)
Insurance Company Phone Numbers	Insured's SS N Patient's Relation To Insured
Member ID#	Insured's Employer
Group #	Insured's Occupation

Secondary Insurance

Who is the secondary insured party (check one) ☐ Patient ☐ Mother ☐ Father ☐ Other_____________

Insurance Company Name:	Insured's Name: First, Middle, Last
Insurance Company Address:	Insured's Address: City, State, Zip
Insurance Company City, State, Zip	Insured's Date of Birth Insured's Sex (M or F)
Insurance Company Phone Numbers	Insured's SS N Patient's Relation To Insured
Member ID#:	Insured's Employer:
Group #:	Insured's Occupation:

Authorization and Acknowledgement

I hereby assign payment of dental benefits to Dr. Bart Miller/ Rockwall Crossing Orthodontics for all services rendered. I understand that I am financially responsible for all charges, whether or not paid by the above said insurance companies.

Date:____________________ Signature:____________________________________

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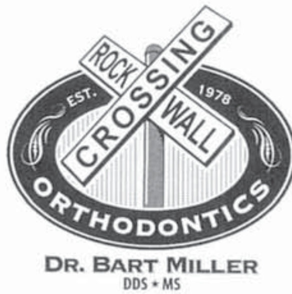

DR. BART MILLER
DDS • MS

Patient Name:___________________________________

Thank you for choosing us for your orthodontic needs. The following policies are intended to benefit our patients and enable us to continue to provide outstanding care.

Please review the policies below.

- Fees for services are payable at the time of visit. We offer several options for payment including cash, checks, MasterCard/Visa, Discover, and MasterCard/Visa backed Debit cards, as well as third-party payment plans.

- A divorce decree is a legal agreement binding only the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills; the parent who brings the child to the office for treatment is responsible for payment at the time of service. The parents can settle the financial responsibilities between themselves.

- If you are covered by insurance, we will need a copy of your insurance card. As a service to you, we will assist you in processing your claims; however, you are ultimately responsible for all charges, whether or not paid by your dental insurance.

- We make every effort to be on time for our patients and we ask that you extend the same courtesy to us. If you arrive late to your appointment, it may impact our ability to perform. We may be required to reschedule the appointment, delaying necessary treatment. Should an emergency occur which delays our seeing you promptly; we will do our best to notify you. We ask you for your understanding in the matter

Thank you for your adherence to these policies.

_______________________________________ ___________________________

Patient Signature (Parent/Guardian Signature) Date

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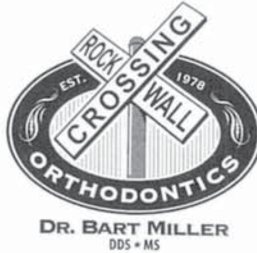

Dr. Bart Miller DDS, MS
Orthodontics

NOTICE OF PRIVACY PROCEDURES

We are committed to dealing honestly with our patients and their families and making our decisions with their best interests at heart. This includes protecting personal information regarding your health

This notice describes how health information about you may be used and disclosed and how you can obtain access to this information.

Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required 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 set forth in this notice while it is in effect. This notice takes effect on 04/15/2003 and will remain in effect until further it's revised

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes to our privacy practices and the changes of our new Notice effective for all the health information we maintain, including health information we received or created prior to making 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 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 or disclose your health information to another healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. These may include but are not limited to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to the above uses you may give us permission in writing to use your health information or 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 while your authorization was in effect. Unless you provide a written authorization, we cannot use or disclose any of your health information except as described in this notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient rights Section of this Notice. We may disclose your health information to a friend, family member, or other person to the extent necessary to aid with your healthcare or the payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use health information to notify or assist in the notification of a family member, your personal representative, or another person responsible for your care of your location, general condition, or death. If you are present then you will be given opportunity to object to such uses or disclosures. In the event of emergency circumstances or your incapacity, we will disclose, using our professional judgement, only information that is directly relevant to their involvement in your healthcare. We will also use our professional judgement and experience along with common practice to make reasonable inferences of your best interest in allowing other persons to pick up your prescriptions, x-rays or other similar forms of health information.

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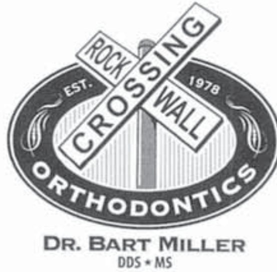

DR. BART MILLER
DDS • MS

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We use or disclose healthcare information when required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably suspect that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to the health or safety of you or others.

National Security: We may disclose health information of Armed Forces personnel to military or other authorized federal authorities in certain circumstances. These circumstances include when such health information is required for national security issues.

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

PATIENT RIGHTS

Access: You have the right to view or obtain 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 it is impractical to do so. Requests to see your health information must be in writing. For providing copies we may charge you a reasonable, cost-based fee.

Disclosure Accounting: You have the right to receive a list of instances of the times we or our business associates disclosed your health information for purposes other than those allowed above. Such accounts may go back up to 6 years, but not before April 14, 2003. If such a request is made more than once in any 12-month period we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on the 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 the case of an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing and specify the means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location proposed.

Amendment: You have the right to request that we amend your health information. Such a request must be in writing and fully explain the rationale for the amendment. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice by electronic means, you are authorized to receive it in written form as well.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have communicate with you by alternative means or at alternative locations, you may complain to us using the information listed at the end of this Notice. You may also 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 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.

Contact Officer: Dr. Bart Miller
Telephone: 972-772-2227 Fax: 972-771-1553
Address: 771 S. Goliad St
Rockwall, TX 75087

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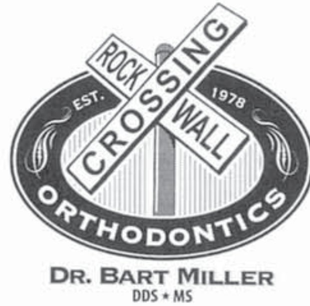

DR. BART MILLER
DDS * MS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Dr. Bart Miller's Notice of Privacy Practices, which has an effective date of 04-15-2003 and describes how my health information may be used and disclosed.

I understand that Dr. Bart Miller has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact Dr. Bart Miller's at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have read the Notice of Privacy Practices and have been offered the opportunity to receive a copy of these privacy practices.

X______________________________ __________________

Signature of Patient or Patient's Representative Date

______________________________ Patient's Name: __________________________

Print Name (Minor/Dependent) Please Print

____

Relationship to Patient (If not signed by the Patient)

You may discuss my treatment and account with the following individuals

______________________________ __________________

Name Relationship

______________________________ __________________

Name Relationship

______________________________ __________________

Name Relationship

X______________________________ __________________

Signature of Patient or Patient's Representative Date

____

Relationship to Patient (If not signed by the Patient)

If you wish to remove anyone from your list is must be done so in writing.

<u>For Office Use Only</u>

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prohibited us from obtaining the acknowledgement
- ☐ Other (Please Specify)

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