ADVANCED
DENTISTRY OF AMARILLO
Aesthetic Smile Design • TMJ • Sleep & Airway
Trey H. Miller, DDS, FAGD, LVIF

6834 Plum Creek Drive • Amarillo TX 79124 (806) 358-8021

New Patient Form

Patients Name: Last: _____ First: _____ MI: ___ Preferred Name: _____

Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Mobile: _____ Work: _____ Ext:_____

Birth Date: _____ Email Address: _____ Best Number to Call:_____

Gender:
☐ Male ☐ Female

Preferred Appointment Times:
☐ Anytime ☐ Morning ☐ Afternoon ☐ Mon ☐ Tues ☐ Wed ☐ Thurs

May we ask how you heard about our Office?

☐ Another Dental Office ☐ Physician ☐ Internet ☐ Magazine ☐ TV

☐ Google ☐ Bing ☐ Yelp ☐ Facebook ☐ Friend

☐ Other: _____

If a specific person referred you to our office please list their name here so we may thank them:

_____

_____

_____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information (If other than Patient)

The Following is for ☐ The patient's spouse ☐ Patients parent/guardian
☐ Other person responsible for payment

Name: Last: _____ First: _____ MI:____ Preferred Name: _____

Title: Mr/Ms/Mrs/Dr _____ Gender ☐ Male ☐ Female

Birth Date: _____ Email Address: _____

Phone: Home _____ Mobile _____ Work _____ Ext _____

Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Primary Insurance Information

Primary Dental Insurance

Name of Insured: Last _____ First _____ MI____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Employer Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you have secondary dental insurance?

☐ Yes ☐ No

Primary Medical Insurance:

Name of Insured: Last _____ First _____ MI____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Insured's Employers Name: _____

Employer Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Do you have secondary dental insurance?

☐ Yes ☐ No

Consents and Releases

Please INITIAL and SIGN below:

_____ I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

_____ I hereby authorize Dr. Miller and/or his team members to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care and treatment, and hereby authorize his use for educational purposes in future lectures, and demonstrations by Dr. Miller and/or his team members.

_____ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Miller and/or his team members for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand that I will receive no further financial compensation for the use, at any time in the future, of my testimonials, photos, slides, or videos by Dr. Miller or his team members.

_____ I understand that responsibility for payment for dental services provided by this office for myself or my dependent is solely mine, with full payment due and payable before the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs, and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

_____ I acknowledge that Dr. Miller is an out-of-network provider for all dental insurance companies so that patients are empowered to make their own decisions about their dental treatment, without the interference of a third party insurance company. As a courtesy to our patients, dental benefit claim forms will be completed by our office and given to each patient in a pre-filled envelope to submit to their dental insurance carrier. This way, any dental benefits received will then be sent directly to the patient.

_____ Since each appointment I make is time reserved specifically for me with the doctor or hygienist, I will provide 48 hours advance notice for any appointment cancellations. Advanced Dentistry of Amarillo reserves the right to impose a cancellation fee for appointments canceled with short notice (less than 48 hours) or no-show appointments. Cancellation/no-show fees are: $50 for appointments booked for less than 1.5 hours and $150 for appointments booked for 1.5 hours or longer. Such cancellation fees are non-refundable and must be collected before reserving another appointment time slot.

_____ I have read and understood this entire agreement before signing below, and I have endorsed this agreement voluntarily, without duress, and of my own free will and choice, and I received a copy of this agreement simultaneously upon my endorsing it.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

_____

Response Date

___/___/_____

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Medical & Dental History

Patient Name: _____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in good health? ☐ Yes ☐ No

Within the past year, have there been any changes in your general health? ☐ Yes ☐ No

What is the date (or approximate date) of your last medical exam?
_____

Your Primary Care Physician's name and phone number
_____
_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Have you ever had Botox injections? If so, when was the last one?

WOMEN ONLY: Are you pregnant? Yes___ No___
If Yes, When is the due date? _____
Taking birth control pills? Yes___ No___
Are you taking hormones? Yes___ No___

Health History
Please indicate if you have experienced the following:

Check the box to indicate a yes response.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Pressure High
- ☐ Blood Pressure Low
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatment
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type ____
- ☐ Herpes
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Tumor or Growth
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss, unexplained
- ☐ Other _____

Height:_____ Weight:_____

Social History

Please mark any of the following to indicate YES in response to the question.

- ☐ Do you use recreational drugs?
- ☐ Do you use tobacco products?
- ☐ Do you drink alcohol?
- ☐ Do you consume caffeine?
- ☐ Do you take pain relievers?
- ☐ Do you use antidepressants or sleeping pills?
- ☐ Are you on any blood thinners, including aspirin?

If any of the previous questions are marked, please explain:

_____

_____

_____

Please mark any of the following to indicate YES if you are currently taking or have taken any of the following medications:

☐ Alendronate-Fosomax-oral ☐ Ibandronate-Boniva-oral ☐ Risedronate-Actonel-oral

Family History

Has any member of your family had the following:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Sleep Disorder
- ☐ Obesity
- ☐ Thyroid Disorder
- ☐ Snores
- ☐ Wears CPAP
- ☐ Sleep Apnea

Medications:

List medications, dosages, the reason for taking medication:

_____

_____

_____

Allergies:

Please mark any of the following to indicate YES for allergy:

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Penicillin
- ☐ Iodine
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Sulfa
- ☐ Latex
- ☐ Other
- ☐ None

Do you have any other health issues or allergies?

_____

Dental History

Please mark any of the following to indicate YES in response to the questions:

- ☐ Does your mouth function comfortably and harmoniously?
- ☐ Does your smile look exactly like you want it to?
- ☐ Are you fearful?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Are any of your teeth causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures or partials?

Your dental health is very important to us. Please indicate if you have experienced the following. Marking the box indicates a YES response. Leaving the box blank indicates a No response.

Posture:

☐ Back Pain	☐ Facial Pain	☐ Postural Problems
☐ Cervical Pain (upper neck)	☐ Lip or cheek biting	☐ Swelling in ankles or feet

Teeth:

☐ Braces: when_____	☐ Dry mouth	☐ Bad breath
☐ Extracted teeth	☐ Bleeding gums	☐ Food collects between teeth
☐ Blisters on lips or mouth	☐ Infected or swollen gums	☐ Clenching teeth
☐ Loose teeth	☐ Diet limited to liquid or soft foods	☐ Poor fitting appliance
☐ Difficulty chewing	☐ Receding gums	☐ Difficulty speaking
☐ Sensitivity to biting	☐ Difficulty swallowing	☐ Sensitivity to hot, cold or sweets

Jaw Joint:

☐ Clicking or popping jaw	☐ Jaw locks open	☐ Pain around ear	☐ Ear congestion
☐ Jaw pain or tiredness	☐ Pain when chewing	☐ Grinding teeth	☐ Limited opening
☐ Pain when swallowing	☐ Headaches	☐ Migraines	☐ Ringing in the ears
☐ Jaw joint noises	☐ Morning head pain	☐ Tingling in jawbone	☐ Jaw locks closed
☐ Numbness in jawbone			

Sleep:

☐ CPAP intolerance ☐ Mouth breathing ☐ Daytime fatigue

☐ Nighttime choking spells ☐ Frequent heavy snoring ☐ Significant daytime drowsiness

☐ Gasping when waking up ☐ Sleepy while driving ☐ Morning hoarseness

Neurologic:

☐ Bell's Palsy ☐ Numbness in lower lip ☐ facial or trigeminal neuralgia

☐ Paresthesia of fingertips (tingling) ☐ Gagging easily ☐ Vertigo (dizziness)

☐ Muscle twitching

Other:

☐ Digestive problems ☐ Nutritional disorder ☐ Fingernail biting

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

Signature of patient, parent or guardian:

Signature_____ Date_____

Response Date:

_____/_____/_____

Infant Questionnaire

Patient's Name_____ Male_____ Female_____

Today's Date _____ Birth Date _____ Medical Problems_____

Heart Disease _____ Bleeding Disorder_____ Other_____

Birth Weight _____ Present Weight _____ Birth Hospital_____

Vaginal Birth _____ C-Section_____ Any birth complications?_____

Are you presently breastfeeding? Yes ____ No____ If no, how long since you stopped?_____

Medical History:

1. Did your child receive the vitamin K shot? Yes_____ No _____
2. Was your infant premature? Yes_____ No_____ If so how many weeks? _____
3. Does your infant have any heart disease? Yes_____ No _____
4. Has your infant had any surgery ? Yes_____ No _____
5. Has your infant experienced any of the following? Please check all that apply.

_____ Shallow Latch at breast or bottle
_____ Falls asleep while eating
_____ Slides or pops on and off nipple
_____ Colic Symptoms/ cries a lot
_____ Reflux Symptoms
_____ Clicking or smacking noise when eating
_____ Spits up Often
_____Gagging, chocking, coughing when eating
_____ Gassy/ Fussy a lot
_____ Poor Weight Gain
_____ Hiccups Often
_____ Lip curls under when nursing/bottle

_____ Gumming/chewing your nipple while nursing
_____Pacifier falls out easily/ doesn't like
_____Milk dribbles out of mouth while nursing/feeding
_____ Short sleeping requiring feeding every 1-2 hours
_____ Snoring, noisy breathing or mouth breathing
_____Feels like a full time job to feed your baby
_____ Nose congested often
_____ Baby is frustrated at the breast or bottle

How long does your baby take to eat? _____
How often does your baby eat? _____

6. Is your infant taking any medication? ____ Reflux_____ Thrush_____ Name of Medication_____
7. Has you infant had a prior surgery to correct the tongue or lip tie? If yes when, where and by whom? _____
8. Do you have any of the following signs or symptoms? Please check all that apply.

_____Creased, flattened or blanched nipples
_____ Lipstick shaped nipples
_____Blistered of cut nipples
_____ Bleeding Nipples
_____Pain on a scale of 1-10 when 1st latching
_____Pain on a scale of 1-10 when nursing

_____Poor or incomplete breast drainage
_____ Infected nipples or breasts
_____Plugged ducts/ engorgement/ mastitis
_____ Nipple Thrush
_____Using a nipple shield
_____ Baby prefers one side over the other ___R/L

Pediatrician_____ Phone Number_____
Lactation consultant _____ Phone Number_____
Who referred you to us?_____

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Excellence in Cosmetic & Comprehensive Care

Informed Consent for Frenulectomy Procedure

I, _____, hereby consent for Dr. Trey Miller to perform the Frenulectomy treatment procedure. This permission is for myself (or minor child) named below. I fully understand this consent for surgery and the reasons why the recommended treatment is necessary. I have been given the opportunity to ask questions regarding the recommended treatment and have been given satisfactory answers. I understand that no guarantee regarding the treatment has been made or implied. I also understand and consent to the following:

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent communicating with my other medical practitioners to inquire about any aspect of my health history.
2. The nature and purpose of the procedure have been explained to me and no guarantee can be made about treatment outcome. Alternative methods of treatment have been explained to me.
3. I also consent to the administration of local anesthesia. I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding, swelling, discomfort, nausea, infection; I agree to abide by the doctors post-operative instructions and that my failure to properly care for my health may lead to further complications.
4. I will pay in full any cost of treatment according to the office's financial policy. I understand that even if an insurance pre-estimate is give or a procedure has been preapproved, I am responsible for any and all costs that my insurance does not cover.
5. I am welcome to ask questions about any aspects of my care and will request information if I am confused or need more information. I am responsible to clarifying any aspects of my treatment that I am unsure about.

CONSENT & AUTHORIZATION

I hereby authorize treatment and agree to pay all related professional fees. Fees not covered by my insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Trey Miller. Without any reservations, I agree to abide by the policies outlines herein.

Form Completed By:

Name: _____

Signature: _____

Date: _____/_____/_____

Office Acknowledgement:

Name: _____

Signature: _____

Date: _____/_____/_____

On behalf of Minor Child:_____