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 ☐ Accent West 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 their 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 their use for educational purposes in future lectures, and demonstrations by Dr. Miller and/or their team members.

_____ I hereby give my permission to have my testimonials and/or photos, slides, and videos utilized by Dr. Miller and/or their 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 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-Fosamax-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
- ☐ Cervical Pain (upper neck)
- ☐ Facial Pain
- ☐ Lip or cheek biting
- ☐ Postural Problems
- ☐ Swelling in ankles or feet

Teeth:

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

Jaw Joint:

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

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:

_____/_____/_____