Drs. Miller & Beitz

Patient Health History Form

Legal Name:_____ Gender: _____ Age: _____ Date of Birth: _____

Preferred Name: _____ Marital Status: _____

Address: _____ City, State, Zip: _____

Home Phone: _____Business Phone: _____ Cell Phone: _____

Employer/School: _____ Occupation: _____

Email address: _____ Preferred Pharmacy: _____

Name of Dentist: _____ How Long: _____ Last Visit: _____

Name of Physician: _____ How Long: _____ Last Visit: _____

Referred by: _____ Reason for Visit: _____

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

Medical History

Are you currently being treated for a medical condition? ☐ No ☐ Yes _____

Do you have or have you ever had any of the following? Check all that apply.

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Congenital Heart Disease
- ☐ Contact Lenses
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Esophageal Reflux/GERD
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ General Anesthesia
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Hearing Problems
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Injury to Head or Neck
- ☐ Intellectual Disability
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nasal Obstruction
- ☐ Osteoporosis/Osteopenia
- ☐ Pace Maker
- ☐ Physical Therapy
- ☐ Pneumocystis Pneumonia
- ☐ Pregnancy
- ☐ Professional Counseling
- ☐ Prostate Problems
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Infection
- ☐ Shingles
- ☐ Sinus Problems/ Hay Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Latex
- ☐ Penicillin
- ☐ Other: _____
- ☐ Sulfa Drugs
- ☐ Tetracycline

What medicines are you currently taking including prescriptions, over the counter, herbal, and vitamins, such as:

- ☐ Antibiotics
- ☐ Anticoagulants
- ☐ Aspirin/Tylenol/Advil
- ☐ Birth Control
- ☐ Cortisone, Steroids
- ☐ Digitalis
- ☐ Diuretics
- ☐ Nitroglycerine
- ☐ Tranquilizers
- ☐ Other: _____

_____

List any hospitalizations/surgeries: _____

_____

Do you smoke, vape or chew tobacco? ☐ Yes ☐ No If so, how often? _____ and for how long _____

Do you drink alcohol? ☐ Yes ☐ No If so, how often? _____

Family History: ___Diabetes ___Heart Disease ___Periodontal Disease

Please add anything you feel is important to know about your health: _____

_____

Dental History

Do you have any of the following? Check all that apply.

☐ Bleeding Gums	☐ Fear of Dental Treatment	☐ Tooth Pain
☐ Clenching/Grinding Teeth	☐ Shifting Teeth	☐ Tooth Sensitivity
☐ Sores/Lumps in Mouth	☐ Missing Teeth	☐ Unpleasant Taste/Smell
☐ Other: _____		

How often do you visit the dental hygienist? _____ When was your last dental hygiene visit? _____

How often do you brush your teeth? _____

What kind of toothbrush do you use? ☐ Electric ☐ Manual ☐ Unsure ☐Other _____

Do you use dental floss regularly? ☐ Yes ☐ No

Have you had periodontal treatment before? _____ If yes, what was the treatment rendered?

_____

_____

Have you had orthodontic treatment before? _____

If there is anything you could change about your smile what would it be?

_____

_____

THE ABOVE STATEMENTS ARE CORRECT AND I CONSENT TO EXAMINATION AND TREATMENT. I AGREE TO BE RESPONSIBLE FOR FEES ACCRUED DURING TREATMENT AND ANY ATTORNEYS FEES OR COURT COST THAT MAY ARISE IN COLLECTION OF THOSE FEES.

Date _____ Signature _____ Relationship _____

Printed Name: _____

DRS. MILLER & BEITZ
Implants and Periodontics of Richmond

Dental Insurance Information

Drs. Miller & Beitz does not participate with any insurance company, however we submit claims to your insurance company as a courtesy. In order to provide a timely response from your insurance company, all information must be provided at time of initial visit. Please note, we do not accept Medicare.

Primary

Insurance carrier _____

Subscriber's name_____ Relationship to patient _____

Subscriber's information

Date of Birth ___ / ___ /___ SSN: _____

Employer_____

Occupation _____

Group #: _____ Subscriber ID: _____

Secondary

Insurance carrier _____

Subscriber's name _____ Relationship to patient_____

Subscriber's information

Date of Birth ___ / ___ /___

Employer_____

Occupation _____

Group #: _____ Subscriber ID: _____

Authorization- To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment/activities in connection with my scheduled treatment plan.

_____ _____

Signature of Patient/Responsible Party Date

Revised 9/12/2024

DRS. MILLER & BEITZ
Implants and Periodontics of Richmond

Financial Policy

Drs. Miller & Beitz are committed to providing the best treatment and service for our patients. Your clear understanding of our financial policy is very important to our professional dental relationship and must be reviewed and signed prior to treatment.

Full payment is due at the time of service unless previous arrangements are made with our business office.
All payments are due at the time of service.
We accept Cash, Personal Checks, Visa, MasterCard, American Express, Discover and tap to pay from a smartphone.

Insurance – We are a non-participating provider for all insurance companies. Your insurance and personal payment portion is your responsibility. As a courtesy, we will file claims to your insurance company. This means that at the time of service we will require the difference of your insurance company's expected payment and our charges. Our staff will explain the good faith payment for each of our services. **Please note our fees are not negotiable on any service regardless of your insurance company's arbitrary determination benefits.**

- Medicare – We are non-participating providers for Medicare. This means we are not able to submit Medicare claims, nor is the patient able to submit claims for any services rendered in this office.

Financial Arrangements – Financial arrangements must be determined before any treatment begins and will only be extended to patients having periodontal treatment over $1,000.00. Fees and time frame will be discussed prior to beginning treatment. We have several options available which will be discussed when you meet with a treatment coordinator.

Broken Appointments/Short Notice Cancellations – A phone call and/or letter will be extended to patients who do not show for their appointment. We request a 24-hour notice if you are unable to keep your scheduled appointment. We reserve the right to charge and collect fees for appointments that are canceled or broken without 24 hours advanced notice. Appointments are reserved exclusively for you. If canceled or broken, the time is taken away from other patients who are waiting to be placed in our schedule.

After the first broken appointment, a notice will be given stating the procedure that will be followed in the future. After the second consecutive broken appointment, a missed appointment fee will be assessed to your account.

Agreement – I understand that I am financially responsible for all charges. I understand that payment in full is due within thirty (30) days after the first billing. I agree and understand that a FINANCE CHARGE of 1.5% per month will be applied on any balance over sixty (60) days past due, which is an ANNUAL RATE of 18%. I understand that in the case of insufficient funds, a returned check fee of $30.00 will be assessed. Should this account be referred to our attorney or a collection agency, I agree to pay all collection and/or court costs, including attorney's fees plus the total indebtedness.

Printed name of Patient/Responsible Party: _____

Signature of Patient/Responsible Party: _____

Date: _____

Any questions regarding this information can be answered by our office team at 804-285-4867

Revised 9/12/2024

DRS. MILLER & BEITZ
Implants and Periodontics of Richmond

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY Drs. Miller & Beitz, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request, you may:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We reserve the right to say "no" but will tell you why in writing within 60 days.
- Ask us to communicate with you in a specific way (for example, home or mobile phone), or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request and reserve the right to say "no" if it would affect your care.
- Ask us not to share information with your insurance company if you pay for a service in full out of pocket. tWe will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact Lisa Sanchez in person at 700 Old Richmond Ave. Suite C-14 Richmond, VA 23226, via phone at (804) 285-4867, or via email at lisa@richmondperio.net
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

DRS. MILLER & BEITZ
Implants and Periodontics of Richmond

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we will never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes
    - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your dental insurance plan so it can participate in payment for your treatment.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Lisa Sanchez – Office Administrator
lisa@richmondperio.net
804-285-4867

DRS. MILLER & BEITZ
Implants and Periodontics of Richmond

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

*Address:*_____

_____

I have received a copy of the Notice of Privacy Practices for Drs. Miller & Beitz

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

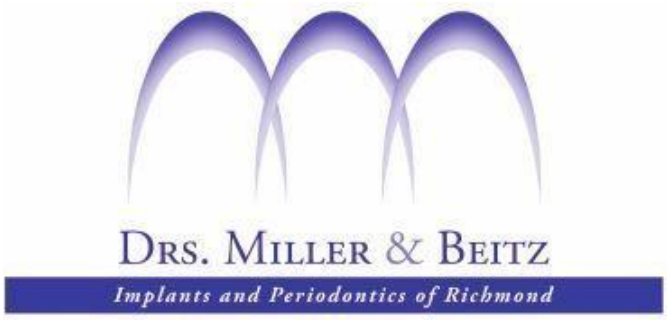
- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

Revised 9/12/2024



DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

A staff representative of Drs. Miller & Beitz has explained to me that disclosures may be made to family and friends related to my health or to obtain payment for healthcare services. I understand that Drs. Miller & Beitz will only disclose information relevant to current treatment.

My healthcare information may be disclosed to the following individuals:

Name	Relationship to Patient

Our staff will not make disclosures to any person(s) not listed in the above table.

Any disclosures made by staff to the above listed individuals will be documented in the patient record in summary format detailing the date of disclosure, the person with whom the information was discussed, what information was discussed and the name of the employee making the disclosure.

_____ _____

Patient Signature Date

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