Valley View Dental Jennifer Miller DDS

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1302 Marshall Street • St. Peter, MN 56082
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(507)934-3332

Welcome to our Practice

Chart#: SE0016
FOR OFFICE USE ONLY

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

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ ____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

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

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

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 Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ ____ _____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached you teeth
☐ Have you experienced popping and/or clicking of your jaw joint
☐ You have difficulty chewing
☐ You clench or grind your teeth
☐ You wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I understand that I am responsible for all charges whether or not they are covered by insurance. A finance charge of 21% per annum will be added to accounts not paid when due in monthly installments. An account may be declared in default if not paid in full in 90 days. The undersigned accepts the fee charged as lawful debt and promises to pay said fee including cost of collection, attorney fees, and court costs if such be necessary. Minnesota State Law requires that both parents are responsible for the account of the minor no matter what state they reside in.

☐ ***By checking this box, I acknowledge that I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Date * _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Response Date: ____/____/_____

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Medical History

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Acid Reflux
- ☐ Allergy-Codeine
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Allergy-RedDye No.40
- ☐ Allergy-Seasonal
- ☐ Allergy-Sulfa
- ☐ Allergy-Tetracycline
- ☐ Anti -Depressants
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Dementia
- ☐ Dental Implants
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Immune-Compromised
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ MitralValve Prolapse
- ☐ MS/Lupus
- ☐ Osteoporsis Meds
- ☐ Other
- ☐ Pacemaker
- ☐ PreMed
- ☐ Radiation TX
- ☐ Reheumatic Fever
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems

- ☐ Hospitalized in the past 5 years (illness or injury)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List or check all medications (prescription and non-prescription) including regular doses of aspirin:

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: ____/____/_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient name: _____
Last First MI Maiden or Other Name

Date of Birth: ____-____-____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize Dr. Miller to disclose the following records related to the individual listed above:

Records: ◯ All records ◯ Diagnostic Records (x-rays)

◯ Treatment Records ◯ Billing/Claims Records ◯ Appointments

The individual(s) below are authorized to communicate about the above marked items.

Individual 1:	Individual 2:	Individual 3:
Name: _____	Name: _____	Name: _____
Phone: (___)_____	Phone: (___)_____	Phone: (___)_____
Relationship: _____	Relationship: _____	Relationship: _____

If the person receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to those listed, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:

Valley View Dental
1302 Marshall Street
St. Peter, MN 56082

***PLEASE NOTE: Revocations do not apply to information that has already been disclosed prior to revocation being received.**

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing.

_____ _____
Patient or Legal Representative Signature Date

_____
Print Patient or Legal Representative Name/Relationship

Failed/cancellations and Missed appointment Policy

As a courtesy to other great patients like yourself, please give us a minimum of 24 hours advance notice so we can adequately change our schedule to help other patients who have been waiting to get in for their dental needs.
We need your help in keeping our schedule flowing properly to accommodate all patients; this can only be achieved if you give us 24 hours or more advance notice.
We regret having to charge a $75 cancellation fee, but it is the only way to ensure we are all on the same page when it comes to staying on time and not letting another patient miss out a slot to get their treatment if we are not given ample notice of 24 hours or more.

You must reach us, call our office at least 24 hours in advance and, speak to a team member directly. Voicemails and Text messages are unacceptable to cancel appointments. This also includes weekends when we are not here and we are open Fridays half day until 12:00 noon. If you have an appointment on a Monday you must reach us directly on Friday before noon.

Valley View Dental will allow you to schedule again, however, if there is a second time where we do not receive 24 hours in advance you will be charged a $100 missed appointment fee plus there will be an additional $150 deposit due at the time of scheduling to hold your future appointments.

This $150 will be applied to your treatment at the next appointment. If two missed appointments occur within one year a 50% rescheduling fee will be required, of the dental procedure you are scheduled for, to hold that appointment.

We set this in place to ensure all patients can be seen for their dental needs and no one misses out on their dental care due to missed appointments.

_____ _____

Sign Date