DENTAL/MEDICAL HISTORY

Name: _____ Age: _____

Occupation: _____ Referring Dr: _____

Chief Dental Complaint: _____

Have you been under the care of a physician or have been hospitalized in the past two years? If yes,

why? _____

List any current medications: _____

_____

List allergies to any medications: _____

Do you smoke? ☐No ☐Yes If so what and how much? _____

Have you ever been premedicated prior to dental treatment? ☐No ☐Yes

DO you have any of the following conditions?

☐ Pregnancy or Nursing	☐ Cardiac Pacemaker	☐ Epilepsy or Seizures
☐ Diabetes	☐ High Blood Pressure	☐ Psychiatric Treatment
☐ Heart Trouble	☐ Artificial Heart Valves	☐ Asthma
☐ Heart murmur	☐ Kidney Treatment	☐ Allergies
☐ Mitral Valve Prolapse	☐ Hepatitis: A☐ B☐ C☐	☐ Tuberculosis
☐ Stroke	☐ Liver Disease	☐ Bleeding Disorder
☐ Artificial Joints	☐ Cancer treatment	☐ HIV/AIDS
☐ Pregnancy or Nursing	☐ Substance Abuse or Addiction	☐ Covid 19/Coronavirus

If you have any other health problems, please explain: _____

_____

How often do you brush each day? _____ How often do you floss _____

Do you have any discomfort? ☐No ☐Yes Do your gums bleed? ☐No ☐Yes When? _____

Is there anything that you want the doctor to be aware of? _____

To the best of my knowledge, the above information is accurate and correct.

_____ _____

Signature Date

PATIENT DENTAL INSURANCE INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

City:_____ State and Zip:_____

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone: _____ ☐ Home ☐ Cell ☐ Work

Emergency Contact:_____ Phone:_____

Marital Status: ☐ Single ☐ Married/Partner ☐ Other: _____

Primary Dental Insurance: _____

Subscriber Name:_____ Date of Birth:_____

Subscriber Soc Sec #_____ Relationship to Patient_____

Subscriber ID #:_____ Group #:_____

Phone # for Pre-authorization:_____

Mailing Address:_____

City:_____ State and Zip:_____

Subscriber Place of Employment:_____

Secondary Dental Insurance: _____

Subscriber Name:_____ Date of Birth:_____

Subscriber Soc Sec #_____ Relationship to Patient_____

Subscriber ID #:_____ Group #:_____

Phone # for Pre-authorization:_____

Mailing Address:_____

City:_____ State and Zip:_____

Subscriber Place of Employment:_____

Valley Implants and Periodontics

Brian J. Miller, DMD

Practice Limited to Periodontics and Dental Implants

52 Highland Ave.

Bethlehem, PA 18017

610-865-6461

brianmillerdmd.com

Dear Patient of Valley Implants and Periodontics,

We are pleased to welcome you as a new patient. Our primary mission is to deliver the best and most comprehensive dental and periodontal care available. An important part of this mission is making the cost of optimal care as easy, flexible and manageable for our patients as possible.

We do offer the courtesy of billing the insurance company for you whenever possible. Your insurance is a contract between you, your employer and the insurance company. You should be aware of your coverage, maximum annual benefits, deductibles and copayments. We have no control over these items. If you surpass these thresholds, you are responsible to pay the balance. We can perform a preauthorization to give a more accurate estimate of what your insurance does cover.

To assist you with your dental care and investment, we provide the following options:

1. Cash including money orders and personal checks
2. Visa/Mastercard
3. CareCredit – A patient payment plan that allows one to pay over a set time with convenient low monthly payments. With CareCredit the benefits include:
    A. Flexible financing options
    B. No annual fees or prepayment penalties
    C. Quick and easy application
    D. The convenience of a credit decision almost immediately but subject to credit approval
    E. The ability to start treatment immediately

We are happy to offer these choices so that you can select a payment option that best fits your needs. If you need more information on CareCredit or if you have any other financial questions, please let us know so that you can make an informed decision on your payment options.

I understand and agree that regardless of my insurance status or reimbursement amounts from the insurance company, I am ultimately responsible for the balance on my account for any professional services rendered. **We kindly ask for a 24-hour notice in case of cancellation and we reserve the right to charge $25 for a non-surgical appointment and $50 for surgical or Scaling and Root planning appointments.**

Signature: _____ Date: _____

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Valleyimplantsandperio.com

I have reviewed/read a copy of the Notice of Privacy Practices for the office of Valley Implants and Periodontics. I am aware a copy is available for me to keep.

_____

Please Print Name

_____

Signature

_____

Date

If we must leave a voice message, please provide the number that is most private and best for you:

_____ ☐ Home ☐ Cellular ☐ Work

For office use only

☐ Individual refused to sign

☐ Communication barrier prevented obtaining the acknowledgement

☐ Other: _____

_____