JONATHAN D. MILES, D.D.S.
510 SOUTH MAIN
SMITHFIELD, UT 84335
(435)563-3266

MEDICAL HISTORY

PATIENT NAME: ______________________________

DATE OF BIRTH: _____/_____/______ SOCIAL SECURITY #: ____________________

HOME PHONE: ________________ CELL PHONE: ____________________ TEXT: Y___ N___

EMAIL ADDRESS: ______________________________ BEST WAY TO CONTACT/ REMINDYOU: ______________

ADDRESS: ______________________________ CITY: ______________ STATE: ________ ZIP: ____________

RESPONSIBLE PARTY: ________________________ PHYSICIANS NAME: ____________________________

DENTAL INSURANCE: ______________________ NAME OF INSURED EMPLOYEE: ________________________

PLEASE ANSWER ALL OF THE QUESTIONS YES OR NO AND PROVIDE ANSWERS WHERE APPLICABLE:

1. Do you consider yourself to be in good health? .... YES NO
2. Are you now or have you been under a physician's care within the past year? .... YES NO
   If Yes, specify condition being treated ____________________________
3. Do you take any medications, including birth control pills? .... YES NO
   Please specify name and purpose of medications: ____________________________
   ____
   ____
4. Have you ever taken Phen-Fen or similar appetite suppressants? .... YES NO
5. If Yes on 4, have you seen your physician or cardiologist for a cardiac evaluation? .... YES NO
6. Do you have or have you ever had any heart or blood problems? .... YES NO
7. Have you ever been told that you have a heart murmur? .... YES NO
8. Do you require antibiotic pre-medication for a heart condition, artificial valve or artificial joint? .... YES NO
9. Do you have or have you ever had high blood pressure? .... YES NO
10. Do you bleed or bruise easily? .... YES NO
11. Have you ever been diagnosed as being HIV positive or having AIDS? .... YES NO
12. Have you ever had hepatitis YES or NO or liver disease? .... YES NO
13. Have you ever had: rheumatic fever_____; asthma_____; any blood disorder_____; diabetes_____; YES NO
    rheumatism_____; arthritis_____; tuberculosis_____; venereal disease_____; heart attack_____;
    kidney disease_____; immune system disorders_____; other disease_____?
    If so, specify: ____________________________
14. Have you ever had an unusual reaction or are you allergic to any of the following drugs: YES NO
    Penicillin_____; Aspirin_____; Acetominophen_____; Ibuprofen_____; Codeine_____;
    Barbiturates_____; Sulfa Drugs_____; Other ____________________
15. Are you subject to fainting? .... YES NO
16. Have you ever had any severe reaction to dental treatment or local anesthetics? .... YES NO
17. Are you allergic to any local anesthetic? .... YES NO
18. Do you have any other allergies? If Yes, please describe: ____________________ YES NO
19. Have you ever had a nervous breakdown or undergone psychiatric treatment? .... YES NO
20. Have you ever received counseling for use of alcohol and/or prescription drugs? .... YES NO
21. Have you ever used or are you now using tobacco or alcohol? .... YES NO
22. Women: Are you pregnant? .... YES NO
23. Are you now in pain? .... YES NO
24. How long ago did you last see a dentist? ____________________
25. Who was your previous dentist? ____________________
26. Do you think that your teeth are affecting your general health in any way? .... YES NO
27. Do you have or have you ever had bleeding or sensitive gums? .... YES NO

I HEREBY CERTIFY THAT THE ANSWERS TO THE FOREGOING QUESTIONS ARE ACCURATE TO THE BEST OF MY ABILITY. SINCE A CHANGE IN MY MEDICAL CONDITION OR IN MEDICATIONS I TAKE CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO TAKE THE RESPONSIBILITY TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT.

Signature ______________________________ Date ________________

Signature ______________________________ Date ________________
(Patient, legal guardian or authorized agent of patient)

HEALTH QUESTIONNAIRE ACKNOLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change in medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Jonathan D. Miles and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore of tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: ____

Signature: ______________________________________ Date: ______________
(Patient, legal guardian or authorized agent of patient)

Witness: ______________________________________ Date: ______________

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OFFICE PRIVACY POLICIES
SUMMARY STATEMENT

THIS NOTICE describes the privacy policies of this dental office. This office strives to maintain confidentiality as far as your dental treatment information. In this summary we describe how this confidential dental and health information is used and disclosed and how you can gain access to this confidential information.

BACKGROUND INFORMATION:

We are required by applicable law to maintain confidentiality of dental health information generated for patients during the course of treatment. We are required to notify all patients about our privacy practices and your rights concerning your health information. These office privacy policies take effect as of April 14, 2003 and will remain in effect until amended by this office. We reserve the right to change the privacy practices of this office and the terms of this notice at any time, provided that such changes are permitted by applicable law, and we will make you aware of any changes we make. Our patients are welcome to request copies of our office privacy policies at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT: We may use or disclose your dental health information to dental colleagues, your physician or other health care providers rendering treatment.
PAYMENT: We may use and disclose your dental treatment information through regular mail, fax or electronic transmission to your dental insurance carrier to obtain payment for services rendered. Limited treatment information may also be disclosed to billing services which assist the office in preparing monthly billing statements.
DENTAL PRACTICE OPERATIONS: We may use and disclose your health information in conjunction with our health care operations.
YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or dental practice operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
DISCLOSURE TO FAMILY AND FRIENDS: You have the right for us to disclose your own personal dental health information.
PERSONS INVOLVED IN CARE: We may use or disclose dental health information to identify or assist in the identification of you or a family member in conjunction with a forensic investigation.
MARKETING: We will not use your dental health information or images of your face and/or teeth for marketing communications without your specific written authorization to do so.
SUBPOENA: We may use or disclose your health information when we are required to do so by law through subpoena.
ABUSE OR NEGLECT: We may disclose dental information of minor patients to appropriate authorities if we have reason to believe that they are possible victims of abuse, neglect or domestic violence or the possible victim of other crimes.
APPOINTMENT REMINDERS: We may use or disclose basic dental information insofar as the fact that you have a dental appointment scheduled in the form of appointment reminders such as voicemail messages, postcards, letters, or e-mail messages.

PATIENT RIGHTS

ACCESS: You have the right to read over or obtain copies of your dental health information, with limited exceptions. Utah law (R-156-69-502(7) specifies that original records must remain in the possession of the treating dentist for seven years, but you may request the copies for a nominal fee.

QUESTIONS AND COMPLAINTS: If you want additional information about our privacy policies or have questions or concerns, you should contact our privacy officer. If you believe or are concerned that we may have violated your privacy rights, or you disagree with a decision we made about the access of your dental health information, you may complain by writing to our privacy officer. You may also correspond with the U.S. Department of Health and Human Services. We will provide you with the address of the U.S. Department of Health and Human Services upon request.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have seen/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)

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OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

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

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished 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 insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patients' account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding ninety days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed 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, or at my request for my minor child or ward by the dentist, I agree to pay, therefore, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. 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 to collect monies owed by me. I authorize the release of financially identifiable information concerning my acount, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined hereon.

Signature of Patient, Parent or Guardian	Date	Relationship to Patient

Date ____________

Patient's Name ____________ Birthdate ____________ Age ____________

Address ____________ City ____________ Zip Code ____________

Sex: M____ F____ Patient's Social Security # ____________ Marital Status: M____ S____ W____ D____

Home Phone # ____________ Cell Phone # ____________ Business Phone # ____________

Patient's Occupation ____________

Spouse's Name ____________ Spouse's Soc. Sec. # ____________ Occupation ____________

Spouse's Employer ____________ Bus. Phone # ____________

Person to contact in case of emergency ____________

Address ____________ Phone # ____________ Relationship ____________

Referred by ____________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of responsible party ____________ Relationship ____________

Residence Address ____________ City ____________ Zip Code ____________

Home Phone # ____________ Social Security # ____________

Employer ____________ No. years employed ____________

Employer's Address ____________ City ____________ Zip ____________

Business Phone # ____________

Will dental insurance be involved? ____________ If yes, complete next section.

PATIENT INSURANCE INFORMATION (Use your identification card)

Subscriber's Name ____________ Subscriber's Social Security # ____________

Your relationship to subscriber: Self ____________ Spouse ____________ Child ____________ Other ____________

Name of Insurance Company ____________ Group Number ____________

Address where claim should be sent ____________

Subscriber's Employer ____________ Employer Phone # ____________

SECONDARY INSURANCE

Subscriber's Name ____________ Birthdate ____________

Social Security # ____________ Employer ____________

Insurance Co. ____________ Group # ____________

Address where claim should be sent ____________

Subscriber relationship to patient ____________