MILLER & KORN
Periodontics and Implant Solutions

Robert J. Miller, DMD
Randi J. Korn, DMD

Today's Date_____

Patient's Name _____Date of Birth _____Marital Status: _____

Home Address_____City_____State_____Zip_____

Cell Phone _____Home Phone_____Email_____

Employer_____Social Security #_____Dental Insurance Co._____

Name of Insured _____Relationship_____Insured DOB_____ Insured SSN _____

Patient's General Dentist _____City/State_____How Long _____

Patient's Medical Physician_____City/State_____How Long _____

Who referred you to this office _____Reason for today's visit_____

Pharmacy Name and Phone Number_____

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health. Your answers are for our records only and will be considered confidential.

Health History:

Are you in good health……..Yes____No____

Date of last physical exam_____Are you currently being treated by a physician? …….…… Yes____No____

Are you taking any prescription drugs or medications.…….... ...Yes____No____

If yes, please list_____

Are you taking any over-the-counter medications, vitamins and/or supplements……..Yes____No____

If yes, please list_____

Are you allergic to any of the following:

Local anesthetics "Novocaine"	Yes___No___	Asprin	Yes___No___
Barbiturates, sedatives, sleeping pills	Yes___No___	Codeine	Yes___No___
Penicillin	Yes___No___	Other	
Other antibiotics	Yes___No___		

Indicate which of the following you have had or have at the present: (all items **must** be checked yes or no)

AIDS/ARC/HIV	Yes___No___	Drug addiction	Yes___No___	Low blood pressure	Yes___No___
Alcohol addiction	Yes___No___	Emphysema	Yes___No___	Mental disorder	Yes___No___
Allergies or hives	Yes___No___	Epilepsy or seizure	Yes___No___	Mitral valve disorder	Yes___No___
Anemia	Yes___No___	Fainting or dizziness	Yes___No___	Osteoporosis	Yes___No___
Angina	Yes___No___	Fatigue	Yes___No___	Persistent cough	Yes___No___
Anxiety	Yes___No___	Glaucoma	Yes___No___	Prolonged bleeding	Yes___No___
Arthritis or rheumatism	Yes___No___	Heart disease or attack	Yes___No___	Radiation treatment	Yes___No___
Artificial heart valve	Yes___No___	Heart failure	Yes___No___	Recent weight loss	Yes___No___
Asthma	Yes___No___	Heart murmur	Yes___No___	Rheumatic or scarlet fever	Yes___No___
Blood disease	Yes___No___	Heart pacemaker	Yes___No___	Shortness of breath	Yes___No___
Blood transfusion	Yes___No___	Heart surgery	Yes___No___	Sinus trouble	Yes___No___
Bruise easily	Yes___No___	Hepatitis	Yes___No___	Skin disease	Yes___No___
Cancer	Yes___No___	High blood pressure	Yes___No___	Stroke	Yes___No___
Chemotherapy	Yes___No___	Hip or knee replacement	Yes___No___	Swollen ankles	Yes___No___
Chest pain	Yes___No___	Hypoglycemia	Yes___No___	Thyroid disease	Yes___No___
Cold sores/fever blisters	Yes___No___	Immune system disorder	Yes___No___	Tuberculosis	Yes___No___
Congenital heart lesions	Yes___No___	Kidney disorder	Yes___No___	Ulcers	Yes___No___
Diabetes	Yes___No___	Liver disorder	Yes___No___	Venereal disease	Yes___No___

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Health History Continued:

Have you had any serious illness, operation or have been hospitalized ……..…….. Yes____No____

If yes, please explain_____

Do you have any disease, condition or problem…….. Yes____No____

If yes, please explain_____

In order to prevent complications associated with heart disease, heart murmur, artificial heart valve or artificial joint replacement, it is often necessary to take antibiotics prior to any dental appointment. Please contact your physician or our office before your first appointment if you have any questions regarding premedication. Do you normally premedicate…….. Yes____No____

Do you smoke or chew tobacco ……..…….. Yes____No____

Do you consume alcohol on a regular basis……...Yes____No____

If yes, amount and frequency_____

Do you use recreational drugs……...Yes____No____

Health History for Women:

Are you pregnant ……...Yes____No____

Are you taking birthcontrol ……...Yes____No____

If yes, for how long_____

Have you reached menopause……...Yes____No____

Dental History:

Date of your last dental visit _____

Have you had any problems associated with previous dental treatment ……...Yes____No____

If yes, please explain_____

Have you ever worn braces……...Yes____No____

Do you clench or grind your teeth ……...Yes____No____

Do you experience pain in your jaw joints or facial muscles ……...Yes____No____

Do you wear any removable dental appliance ……...Yes____No____

When was the last time you had x-rays taken and where _____

I certify all the above given information to be true and accurate. The undersigned hereby authorizes the Doctors to perform all necessary procedures deemed appropriate to make a thorough diagnosis of the patients dental or oral-facial needs including x-rays, study models, photographs, medications and the use of local anesthetic agents. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____ _____

Signature of patient (Parent or guardian, if minor) Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT'S NAME: _____ PHONE NO: _____
DATE OF BIRTH: _____ SSN: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice can be given to you now upon request so that you may read it before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice by contacting our office:

Miller & Korn D.M.D.
817 South University Drive #100A Plantation, FL 33324
(954) 791-7530

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue to treat you if you revoke this Consent.

SIGNATURE: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I do hereby acknowledge that I have received a copy of Dr. Miller and Dr. Korn's Notice of Privacy Practices.

NAME: _____
ADDRESS: _____
SIGNATURE: _____ **DATE:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Communication barriers prohibited obtaining the acknowledgement ☐ Individual refused to sign
☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please attach explanation)

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart.

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Miller and Korn Periodontics and Implant Solutions and Your Insurance Company

Employers purchase dental insurance for their employees to supplement the cost of care. Unlike medical insurance, most dental benefits do not cover the full cost of care. If you have dental insurance the staff at South Florida Periodontics and Implant Solutions will review your insurance benefits with you and advise you as to how your coverage will help offset some of the costs of your dental care. If you do not have dental insurance, you will be responsible for paying the office for any services provided. **If the treating doctor is not a participating provider on your insurance you will be responsible for paying the office for any services provided that are not covered by your insurance, and any fees that are above the amount payable by your benefits program.** Listed below are several questions the office receives on a regular basis, and we hope that this helps you to further understand how insurance works.

Do you accept my insurance, and if so, how much will it cover?
We currently accept several private care insurance plans (PPOs), which are plans that do not require you to select a dentist from a list. Although we can maintain computerized histories of payment by a given company, they do change and therefore it is impossible to give you a guaranteed quote at the time of service. We **estimate** your portion based on the most up to date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment estimate" with your insurance company prior to any procedures. This does delay treatment several weeks but will give you a more accurate **estimate** of your out-of-pocket expense.

I thought I paid my portion but I received a bill? Why?
We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a plan deductible (individual or family) or you may have received treatment in another office prior to joining the South Florida Periodontics and Implant Solutions family which is not calculated into our database. Most of our patients see their general dentist for routine care throughout the year, which also uses your annual benefit. If any of these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

Insurance will not cover the service, so now what?
We will exhaust all reasonable avenues for resolution between what we have billed your insurance company and what they have sent as payment. We bill your insurance company as a courtesy, if insurance does not pay within 90 days, South Florida Periodontics and Implant Solutions reserves the right to request payment in full for services from you, and in turn you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot, be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Financial Options:
South Florida Periodontics and Implant Solutions does require payment in full for your portion at the time of service. We accept cash, check, Visa, MasterCard, and Discover. If you are in need of an extended finance option, we work with Care Credit, a company who offers varying monthly arrangements with no interest financing for medical services. Just ask one of our patient care coordinators for an application and further explanation.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at South Florida Periodontics and Implant Solutions.

Patient's Name_____ **DOB**_____/_____/_____

Signature_____ **Date**_____