Frontier Dentistry
FIND YOUR SMILE

129 East 1st Street • Springtown, Texas 76082 • 817-523-4648
dentistryfrontier@gmail.com

Caroline Miller DDS
Hassan Asghar DDS, MS

Today's Date _____

Cell # _____
☐ Voicemail ☐ Text

Email _____

Patient Information (CONFIDENTIAL) Driver's Lic # _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Relationship to Pt _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Start Date/Year of current insurance? _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
If yes, what surgeries or illness? _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Do you use tobacco?	☐	☐
If yes, how much do you smoke or dip? _____/day		
5. Do you use alcohol or other drugs?	☐	☐
6. Are you taking any blood thinning medication, such as Pradaxa, Coumadin, Aggrenox, Effient, Plavix, Warfin, Lovenox, Ticlid, and Heparin?	☐	☐
7. Are you taking any of the following?		
Bone Pills / IV / Fosamax / Etc.	☐	☐
Long-term antibiotics	☐	☐
Nitroglycerin	☐	☐
Recreational drugs	☐	☐

	Yes	No
8. Are you allergic to or have you had any reactions to the following? *(hives, itchiness, throat swelling, etc.)*		
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐
Jewelry / Metals	☐	☐
Other	☐	☐

Please, list additional drugs/materials causing an allergic reaction: _____

	Yes	No
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐	Hemophilia / Excessive Bleeding	☐	☐
Heart Attack	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Swollen Ankles	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Fainting / Seizures	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Cancer	☐	☐	Unexplained Weight Loss	☐	☐
Epilepsy / Convulsions	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
Kidney Diseases	☐	☐	Sexually Transmitted Disease	☐	☐	Psychiatric Problems	☐	☐
AIDS or HIV Infection	☐	☐	Stomach Troubles / Ulcers	☐	☐	Tuberculosis (TB)	☐	☐
Thyroid Problem	☐	☐	Osteoporosis	☐	☐	Long-term steroid therapy	☐	☐
Heart Disease	☐	☐	Congestive Heart Failure	☐	☐	Chemotherapy	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have dry mouth?	☐	☐

	Yes	No
9. Do you have frequent headaches?	☐	☐
10. Do you clinch or grind your teeth?	☐	☐
11. Do you bite your lips or cheeks frequently?	☐	☐
12. Have you ever had any difficult extractions in the past?	☐	☐
13. Have you had any orthodontic work?	☐	☐
14. Have you ever had any prolonged bleeding following extractions?	☐	☐
15. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
16. Have you ever had instructions on the care of your gums?	☐	☐

Dental History

What brings you to the dentist today? _____

_____

Are you currently in pain? ☐ Yes ☐ No

Please rate your pain on a scale of 1-10 with 1 being little pain and 10 being unbearable pain _____

Previous / Present Dentist _____

Street / PO Box _____ City _____ State _____ Zip _____

Phone Number _____

When was your last cleaning? _____ Oral Cancer Test? _____

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

_____

Do you require antibiotics before dental treatment?	☐ Yes ☐ No
Do you still have wisdom teeth?	☐ Yes ☐ No
Are you happy with the way your smile looks?	☐ Yes ☐ No

Please rate your smile on a scale of 1-10 with 10 being the best _____

If I could change my smile, I would:

Whiten my teeth	☐ Yes ☐ No
Make my teeth straighter	☐ Yes ☐ No
Close spaces between teeth	☐ Yes ☐ No
Repair chipped teeth	☐ Yes ☐ No
Replace missing teeth	☐ Yes ☐ No
Have a smile make over	☐ Yes ☐ No

On a scale of 1-10, with 10 being the highest rating:

How important is dental health to you?

Lowest ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *Highest*

How would you rate your current dental health?

Lowest ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *Highest*

Standard of Care at Frontier Dentistry

Fluoride Treatment

I understand that I will receive fluoride treatment at every cleaning appointment unless otherwise requested by me. I also understand that if I choose not to have fluoride for myself or child that it is my responsibility to inform the dental hygienist before the cleaning begins.

X-Rays

I understand that if I am transferring from another dental office, it is my responsibility to inform Frontier Dentistry that x-rays were taken at another dental office. X-rays are standard of care at Frontier Dentistry and will be taken every 12 months or with the doctor's discretion.

Missed Appointments

I understand that when I reserve an appointment with Frontier Dentistry, I am committing myself to the specified day and time. I understand that Frontier Dentistry does not charge a cancellation fee for emergency situations. I also understand that if I abuse the cancellation policy, which requires a 24 hour notice, I could incur a fee of $45.00 if I miss my appointment.

Payment Policy & Insurance

I understand that my payment is due at the time services are rendered. I also acknowledge and agree that payment in full is required if my insurance cannot be verified prior to my appointment.

I understand that Frontier Dentistry files my primary insurance. I acknowledge and agree that it is ultimately my responsibility as the patient/parent to know what my insurance plan covers and any unpaid balance not covered by insurance is my responsibility.

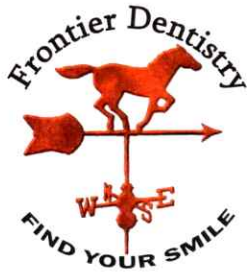
I understand that as the parent, I am responsible for my child while under the care of Frontier Dentistry. I understand that should I allow someone other than myself to bring my child to his/her appointment, that any documents signed by that person or verbal acknowledgments given by that person is ultimately my responsibility and will fall back upon me.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent if minor



Caroline Miller, D.D.S.
Hassan Asghar, D.D.S., M.S.
Family Dentistry

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you the best possible care available. Our office is **NOT** contracted as a provider for **ANY** insurance company due to the limitations they attach to treatment, regardless of the diagnosis. Our commitment is to you, our patient, not to any insurance company.

Your insurance benefits have been negotiated and purchased by your employer, and offered as a benefit to you. The contract between you, your insurance company and your employer. We are not a party to that contract and do not have any specific information regarding your benefits.

As a courtesy, we will assist you in filing electronic claims to receive the maximum **out-of-network** benefits you are eligible to receive. Because we have no guarantee of payment or specific payment amount from your insurance company, we ask that all of our patients secure financial arrangements prior to their scheduled treatment.

We have several options regarding financial arrangements for treatment:

Payments can be made by major credit card

We will file your insurance and you will be required to pay the estimated portion for the procedure

We accept **Care Credit**

If you have any further questions, please feel free to ask. We are here to assist you.

Signature _____ Date _____

P.O. Box 309 • Springtown, Texas 76082 • (817) 523-4648
dentistryfrontier@gmail.com

Frontier Dentistry
Caroline Miller, DDS
Hassan Asghar, DDS, MS

I Consent and acknowledge the receipt of the privacy practices of the office of Caroline Miller, DDS and Hassan Asghar, DDS, MS

Signed: _____ **Date:** _____

Representative if Minor _____

Witness: _____ **Date:** _____

Caroline Miller, DDS
Hassan Asghar, DDS, MS

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.
The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted applicable by law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

MARKETING HEALTH-RELATED SERVICES: WE WILL NOT USE YOUR HEALTH INFORMATION FOR MARKETING COMMUNICATIONS WITHOUT YOUR WRITTEN AUTHORIZATION.

PERSONS INVOLVED IN CARE: We must disclose your health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays, or other similar forms of health information.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to any authorized law enforcement officials health information required for lawful intelligence or other security activities.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure or your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing, and we may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may violated your privacy rights, or you disagree with a decision we made about access to your health information or in a response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Resources. We support your right to privacy of your health information.

CONTACT OFFICER: Christy Bertschy
TELEPHONE: 817-523-4648 FAX: 817-523-4652
ADDRESS: P.O. Box 309
Springtown, Texas 76082