PATIENT REGISTRATION – Dr. Joshua Millsaps

Date: ____________________________

Patient Information:
First Name: _____________________ Last Name: _____________________ Middle Initial: ___________
Address: ____
City: _____________________________________ State: ___________ Zip: _______________________

Home Phone: ________________ Cell Phone: ___________________ ☐ I would like to receive text reminders

Employer: _________________________________ Work Phone: ________________________________

Sex: ☐Male ☐Female

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Birth Date: ____________________ Age: _________ SS#: ____________________________

E-Mail: ____ ☐ I would like to receive correspondences via e-mail

Last Dental Visit: ______________________ Previous Dentist: _________________________________
Whom may we thank for referring you? ____

Responsible Party: (If different than the patient):
First Name: _____________________ Last Name: _____________________ Middle Initial: ___________
Address: ____
City: _____________________________________ State: ___________ Zip: _______________________
Home Phone: _________________ Cell Phone: __________________ Work Phone: _________________
Birth Date: ___________________ SS#: ________________________

Primary Dental Insurance Information:
Name of Insured: __________________________________ Relationship to Patient: ________________
Birth Date: ______________________ SS#: ____________________________
Employer: _____________________________________ Work Phone: ___________________________
Insurance Company: _____________________________ Phone: ________________________________
Address: ____
Group #: ___________________________ Subscriber #: _______________________________________

Secondary Dental Insurance Information:
Name of Insured: __________________________________ Relationship to Patient: ________________
Birth Date: ______________________ SS#: ____________________________
Employer: _____________________________________ Work Phone: ___________________________
Insurance Company: _____________________________ Phone: ________________________________
Address: ____
Group #: ___________________________ Subscriber #: _______________________________________

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Medical History

Are you under a physician's care now? □ YES □NO If yes, explain: ____

Have you ever been hospitalized or had a major operation?

□ YES □NO If yes, explain: ____

Have you ever had a serious head or neck injury? □ YES □NO If yes, explain: ___________________________________

Are you taking any medications, pills, or drugs? □ YES □NO If yes, explain: ____________________________________

Do you take, or have you taken, Phen-Fen or Redux? □ YES □NO If yes, explain: _________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

□ YES □NO If yes, explain: ____

Are you on a special diet? □ YES □NO If yes, explain: ____

Do you use tobacco products? □ YES □NO

Do you use controlled substances? □ YES □NO If yes, explain: ____

Women: Are you…

□ Pregnant/Trying to get pregnant? □ Nursing? □ Taking oral contraceptives?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic

□ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics

Other? ____

Do you have, or have you had, any of the following?

Aids/HIV Positive	□Yes □No	Cortisone Medicine	□Yes □No	Hemophilia	□Yes □No	Radiation Treatments	□Yes □No
Alzheimer's Disease	□Yes □No	Diabetes	□Yes □No	Hepatitis A	□Yes □No	Recent Weight Loss	□Yes □No
Anaphylaxis	□Yes □No	Drug Addiction	□Yes □No	Hepatitis B or C	□Yes □No	Renal Dialysis	□Yes □No
Anemia	□Yes □No	Easily Winded	□Yes □No	Herpes	□Yes □No	Rheumatic Fever	□Yes □No
Angina	□Yes □No	Emphysema	□Yes □No	High Blood Pressure	□Yes □No	Rheumatism	□Yes □No
Arthritis/Gout	□Yes □No	Epilepsy or Seizures	□Yes □No	High Cholesterol	□Yes □No	Scarlet Fever	□Yes □No
Artificial Heart Valve	□Yes □No	Excessive Bleeding	□Yes □No	Hives or Rash	□Yes □No	Shingles	□Yes □No
Artificial Joint	□Yes □No	Excessive Thirst	□Yes □No	Hypoglycemia	□Yes □No	Sickle Cell Disease	□Yes □No
Asthma	□Yes □No	Fainting Spells	□Yes □No	Irregular Heartbeat	□Yes □No	Sinus Trouble	□Yes □No
Blood Disease	□Yes □No	Frequent Cough	□Yes □No	Kidney Problems	□Yes □No	Spina Bifida	□Yes □No
Blood Transfusion	□Yes □No	Frequent Diarrhea	□Yes □No	Leukemia	□Yes □No	Stomach Disease	□Yes □No
Breathing Problems	□Yes □No	Frequent Headaches	□Yes □No	Liver Disease	□Yes □No	Stroke	□Yes □No
Bruise Easily	□Yes □No	Genital Herpes	□Yes □No	Low Blood Pressure	□Yes □No	Swelling of Limbs	□Yes □No
Cancer	□Yes □No	Glaucoma	□Yes □No	Lung Disease	□Yes □No	Thyroid Disease	□Yes □No
Chemotherapy	□Yes □No	Hay Fever	□Yes □No	Mitral Valve Prolapse	□Yes □No	Tonsillitis	□Yes □No
Chest Pains	□Yes □No	Heart Attack/Failure	□Yes □No	Osteoporosis	□Yes □No	Tuberculosis	□Yes □No
Cold Sore/Fever Blister	□Yes □No	Heart Murmur	□Yes □No	Pain in Jaw Joints	□Yes □No	Tumors or Growth	□Yes □No
Congenital Heart Disorder	□Yes □No	Heart Pacemaker	□Yes □No	Parathyroid Disease	□Yes □No	Ulcers	□Yes □No
Convulsions	□Yes □No	Heart Trouble/Disease	□Yes □No	Psychiatric Care	□Yes □No	Venereal Disease	□Yes □No
						Yellow Disease	□Yes □No

Have you ever had any serious illness not listed above: □Yes □No If yes, please explain: ___________________________

Comments:____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X ____ Date: ______________________________

Joshua M. Millsaps, DDS,PA
General, Cosmetic, and Implant Dentistry
935 4th Street Drive NE
Hickory, NC 28601
828.322.2977
www.MillsapsDentistry.com

Financial Policy Agreement

High quality dental care can be a significant investment for patients. Our office wants to do all that we can do make treatment affordable to you and your family.

For patients with insurance: You must provide our office with a current insurance card and all information necessary to verify your coverage and file your claim efficiently.

While we do not participate in PPO plans, we accept most major insurance plans. As a courtesy to you, we are pleased to file any insurance claim.

While we strive to provide you with the best estimate possible for your portion of the payment, insurance reimbursements may vary slightly from what we have predicted. You are responsible for our fees and not what your insurance company allows or considers "usual, customary, and reasonable" all of which vary from one company to another.

If another office has filed or will be filing claims associated with work you have received there (e.g. oral surgeon or other specialist), you may exceed the maximum benefit of your insurance provider without our knowledge. In other words, the insurance payment could be denied to our office or dental payment could be less than estimated due to the maximum benefit.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment. Not all services we provide are covered benefits. Benefits differ from one company to another.

For patients without insurance: Everyone needs routine, preventive dental care, and many of us need restorative treatment. Our office accepts cash, check, Visa, Discover, MasterCard, and American Express. We also participate in Care Credit. To learn more about this program visit www.carecredit.com.

Office Scheduling Policy

In order to be able to see our patients in a timely manner and respect their time, we must have a confirmation of your appointment at least 48 hours in advance of the appointment time. All cancellations will require at least 48 hours' notice. Unless cancelled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit.

In the unforeseen event that the office is running behind, a courtesy call will be made to the patient, so they may reschedule their day, if they desire, to reschedule their appointment should the time change create a problem.

Signature: ____ Date: _____________________________

PLEASE FILL OUT BACK OF THIS FORM

Patient HIPAA Consent Form

Joshua M. Millsaps, DDS,PA
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Hickory, NC 28601
828.322.2977
www.MillsapsDentistry.com

I understand that I have certain rights regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. insurance company)
- The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this __________________ day of ___________________, 20______

Print Patient Name ____

Signature ____ Relationship to Patient ____________________

Other persons to whom we may release the information to:

____ Relationship to Patient ________________________

____ Relationship to Patient ________________________