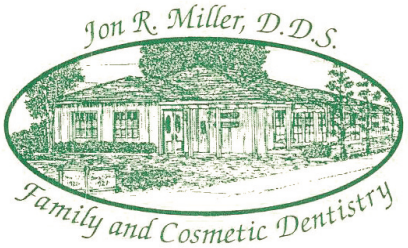
Jon R. Miller, D.D.S.



Family and Cosmetic Dentistry

Welcome!

We thank you for choosing Jon R. Miller as your dental provider. We would like to take this opportunity to tell you a little bit about us. Our office provides general, family, and cosmetic dentistry; we welcome patients of all ages. Our office is open Monday & Wednesday from 9am-6pm, Tuesday & Thursday from 7am-4pm and on Friday mornings by appointment only to accommodate your dental needs.

Dr. Miller received his undergraduate education at the University of Southern California where he obtained his Bachelor of Science Degree in Biological Sciences in 1989. His dental education was completed at the University of the Pacific School of Dentistry in 1992 and his general practice residency was completed at Union City Dental Clinic in 1993. Dr. Miller has been practicing general dentistry in Manhattan Beach Since 1993. During his off time, he enjoys mountain biking, running and spending time with his beautiful wife and daughter.

Kristi, one of our three Dental Hygienists, is in the office Monday, Thursdays & Friday mornings. Kristi attended Fresno State, UCLA and Cypress College as a registered dental hygienist with expanded functions. She has been a hygienist in our office for many years! Kristi is a dedicated UCLA sports fan and an animal lover, she spends her free time attending sports events with friends and enjoying time with her beloved pets.

Laura is available on Tuesdays & Wednesdays. Laura attended the University of Hawaii as a Registered Dental Hygienist with expanded function and has been part of our dental team since 2007. Laura enjoys staying very active, she loves skiing, traveling and spending time with her son and husband.

Kaitlyn is our newest addition as of 2016, she is available every week day except on Mondays. Kaitlyn attended CSU Long Beach and then West Coast University for her dental hygiene credentials. She has been practicing as a hygienist since 2011. Kaitlyn enjoys traveling and spending time with her husband and son. She is a fantastic and appreciated addition to our team.

Our front office staff consist of Laurie who has been here in our office since 2005, and Amanda who joined our team in May of 2011. Laurie has been working in the dental field for well over 25 years and Amanda for 14 years and counting! Together they help to keep the office running efficiently. Laurie enjoys vacationing with her husband and spending time at the local yacht club with friends. Amanda spends most of her off time juggling her 3 school aged kids from activity to activity with her husband, they enjoy visiting different local parks, museums and beaches.

Hilda is Dr. Miller's chairside assistant, his second set of hands! She has been working alongside Dr. Miller for over 10 years and has been in the dental field working as a registered dental assistant for close to 25 years. Hilda and her husband enjoy spending plenty of time with their kids and grandkids.

We work hard to provide dentistry in a gentle and caring manner and hope to make every visit to our office pleasant. Because we value our patients' time we encourage all new patients to complete our registration packet prior to their first visit so that we can see you promptly at your scheduled time; you can either call in and speak to Laurie or Amanda, they will note your email address and send the registration forms out to you via email or you can send an emailed appointment request to Amanda@jrmillerdental.com or Laurie@jrmillerdental.com and the forms will be forwarded to you.

***Cancellation Policy* We kindly request that you provide 24-hour notice for canceling of any appointment in our office; appointments cancelled without 24-hour notice will be subject to $50 broken appointment charge.**

We encourage you to visit our website: www.jrmillerdental.com. Laurie and Amanda are always available via email during regular office hours at amanda@jrmillerdental.com or laurie@jrmillerdental.com

We look forward to meeting you!

921 Manhattan Beach Blvd., Manhattan Beach, CA 90266
Phone (310) 546-5777 • Fax (310) 546-9758

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

LAST NAME | FIRST | M.I

PREFERS TO BE CALLED

ADDRESS

CITY | STATE | ZIP

HOME PHONE # | FAX #

CELL PHONE # | EMAIL

DOB | AGE | MALE ☐ | FEMALE ☐

MARRIED ☐ | SINGLE ☐ | DIVORCED ☐ | WIDOWED ☐

SOCIAL SECURITY #

★ DATE

LAST NAME | FIRST | M.I

PREFERS TO BE CALLED

DOB | AGE | MALE ☐ | FEMALE ☐

ADDRESS

CITY | STATE | ZIP

HOME PHONE #

SCHOOL

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP #

EMPLOYER NAME

INSURED'S NAME

INSURED'S DOB

RELATIONSHIP TO PATIENT

INSURED'S ID #

INSURED'S SSN

SECONDARY CARRIER

INSURANCE COMPANY

GROUP #

EMPLOYER NAME

INSURED'S NAME

INSURED'S DOB

RELATIONSHIP TO PATIENT

INSURED'S ID #

INSURED'S SSN

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE #

ADDRESS

CITY | STATE | ZIP

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU

RELATIONSHIP | PHONE #

ADDRESS

CITY | STATE | ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT | SSN

ADDRESS

CITY | STATE | ZIP

PHONE #

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE # | FAX #

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS | CITY

PHONE # | FAX #

PLEASE TURN OVER AND SIGN

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of

(name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health informations is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand that insurance is billed on my behalf as a courtesy; insurance coverage is an agreement between the insured, the employer, and the insurance company; I am responsible for knowing the details of my insurance coverage. In the event payments are not received by agreed upon dates, I understand that a 2% late charge may be added to my account. Excessively delinquent accounts may be forwarded to a collections agency.

Patients/Parents Signature _____ Date _____

(FOR FUTURE UPDATES)

Treatment and Financial Obligation consent must be updated annually; please review the above details. Your signature below indicates you have reviewed and agree to the above Consent and Financial obligation.

Patients/Parents Signature _____ Date _____

Patients/Parents Signature _____ Date _____

Patient Name	**DENTAL HISTORY**
Patient Account #	Medical Alert

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Phone Number _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe _____

Are any of your teeth sensitive to:			**Have you ever had:**		
Hot or cold?	☐ Yes	☐ No	Orthodontic treatment?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No	Oral Surgery?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No	Periodontal Treatment?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Your teeth ground or the bite adjusted?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No	A bite plate or mouth guard?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No	A serious injury to the mouth or head? If so please describe, including cause _____	☐ Yes	☐ No
Have your parents experienced gum disease?	☐ Yes	☐ No	**Have you experienced :**		
...or tooth loss?	☐ Yes	☐ No	Clicking or popping of the jaw?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No	Pain? (joint, ear, side of face)	☐ Yes	☐ No
Does food tend to become caught in between your teeth? If so, where? _____	☐ Yes	☐ No	Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Do you :			Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Grind or clench your teeth while awake or asleep?	☐ Yes	☐ No	Headaches, neckaches, or shoulder aches?	☐ Yes	☐ No
Bite your lips or cheeks regularly	☐ Yes	☐ No	Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Hold foreign objects with your teeth? (pencils, pipe, fingernails)	☐ Yes	☐ No	**Are you satisfied with your teeth's appearance?**	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No	Would you like to keep all of your teeth all of your life?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No	Do you feel nervous about having dental treatment? If so, what is your biggest concern? _____ _____	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No	Have you ever had an upsetting dental experience? If yes, please describe: _____ _____	☐ Yes	☐ No
Smoke/chew tobacco or use other tobacco products?	☐ Yes	☐ No			

Do you have any other questions or concerns, or anything else you would like us to know regarding your dental health? _____

_____

_____

(Please complete other side)

Patient Name	**MEDICAL HISTORY**
Patient Account #	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you taking any medications or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ☐ Yes ☐ No
   If yes, please list the name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine; and Redux (dexfenfluramine)? ☐ Yes ☐ No
   If yes to the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Do you have any history of an allergic or adverse reaction to any medication or substance? ☐ Yes ☐ No
   If yes, please list: _____
6. Have you been hospitalized during the past five years? ☐ Yes ☐ No
7. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item below:

Heart (Surgery, disease/attack)	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	Hepatitis ☐ A ☐ B ☐ C *(check)*	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No	A.I.D.S.	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	H.I.V Positive	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Blood transfusion	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Allergies or Hives	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Artificial Joints (hip, knee, etc.)	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No

8. Do you use more than two pillows to sleep? ☐ Yes ☐ No
9. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No
10. Do you have any disease, condition or problem not listed? ☐ Yes ☐ No
    If yes, please list: _____
11. Woman: Are you pregnant or think you may be pregnant? ☐ Yes, _____ months ☐ No Nursing? ☐ Yes ☐ No
12. Woman: Do you use birth control medications? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

California

I hereby authorize _____, DDS to release the

information in the dental record of _____ (patient's name) to

_____

(name of dentist, physician, clinic, or patient's representative)

_____

_____

(address)

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____

_____

This authorization is effective now and will remain in effect until _____ (date).
I understand that I may receive a copy of this authorization.

Signature _____ Date

If not signed by the patient please indicate relationship:
☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

NOTE: This authorization is intended to comply with applicable state laws. It is not intended as a "Consent" or "Authorization" for the use and disclosure of Protected Health Information (PHI) under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or its implementing regulations. The medical provider to whom this authorization is directed should ensure that he or she is in compliance with applicable HIPAA requirements before releasing the requested records.

CAUTION: If you intend to use the requested information for any purpose other than providing medical treatment, 45 CFR Section 164.502 requires that you make reasonable efforts to limit your request for PHI to the minimum necessary to accomplish the intended purpose of the request.

To be valid, an authorization must be clearly separate from other language on a page and executed by a signature which serves no purpose other than to execute the authorization. It can either be handwritten by the person who signs it or in typeface no smaller than 8 point (this is 8 point).

Place a copy in the patient's chart.

[10/2017]