Christina P. Mills, D.D.S.

PATIENT REGISTRATION

First Name_____ Last Name _____ M.I. _____

Preferred Name _____ Date of Birth _____ Sex _____

- **Patient is Policy Holder**
- **Patient is Responsible Party**

PATIENT INFORMATION

First Name _____ Last Name _____ M.I. _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ SSN _____ Marital Status ___M___S___DIV___SEP___WID

E-mail address _____

RESPONSIBLE PARTY (if someone other than the patient)

First Name _____ Last Name _____ M.I. _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Date of Birth _____

SSN _____ Marital Status _____M_____S_____DIV_____SEP_____WID

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Rel. to Insured _____SELF_____SPOUSE_____CHILD_____OTHER

Insured ID or SSN _____ Insured Date of Birth_____

Employer _____

Insurance Company _____

Ins. Co. Phone # _____

Ins. Co. Address _____

_____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Rel. to Insured _____SELF_____SPOUSE_____CHILD_____OTHER

Insured ID or SSN _____ Insured Date of Birth _____

Employer _____

Insurance Company _____

Ins. Co. Phone # _____

Ins. Co. Address _____

_____

Christina P. Mills, D.D.S.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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/Dizziness ◯ 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/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ 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 Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ 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 Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 _____ DATE _____

Christina P. Mills, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare options, of the uses of disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely 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, at any time by contacting Christina Mills, D.D.S.

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 Contact Person 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 will decline to treat you or to continue treating you if you revoke this Consent.

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 as described in the "Notice of Privacy Practices".

Signature: _____ ***Date:***_____

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

Personal Representative's Name: _____

*Relationship to Patient:*_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Christina P. Mills, D.D.S., 1701 Sunset Lane, Culpeper, Virginia 22701

(540) 825-1366

Christina P. Mills, D.D.S.

Welcome to our office! We are very pleased that you selected us to provide you with quality dental care and would appreciate you taking the time to read about our financial policies:

1) If you have no dental insurance, payment in full is due from you when services are rendered. We accept cash, check, Visa, MasterCard, American Express, and Discover. If a check payment is returned from the bank, there will be an automatic $25.00 returned check charge added to your account.

2) If you have dental insurance and provide us with complete insurance information, we will complete your claim forms and file them with your insurer carrier at no additional charge to you. You are responsible to pay: a) all co-pay and deductible amounts at the time of service, b) any balance due as determined by your carrier after claims processing.

3) Regardless of insurance coverage, you are ultimately responsible for payment of all services. We file insurance claims daily and promise that we will make every effort to collect all insurance balances due; however, if your carrier does not pay the claim within 90 days, you will be billed for any outstanding remaining balance. Continued negotiations with the carrier will be your responsibility.

4) By my signature on this registration form, I consent to treatment at the office of ***Christina P. Mills, DDS***.

I agree to pay the cost of treatment and if necessary, 45% collection or legal fees. I agree to pay 1.5% (18% APR) interest on any outstanding balance remaining 90 days after the service date.

Signature:_____Date:_____

_____

(Patient, Parent or Guardian)

Christina P. Mills, D.D.S.

Local Anesthesia Consent Form

This consent form is designed to make you aware of the risks involved with local anesthesia. The risks include but are not limited to the following:

A. Adverse reactions affecting your body, such as bruising, hematoma, dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. Any or all of these may require additional medical management or hospitalization.

B. Restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy.

C. Prolonged numbness that in some patients may result in injury from biting or chewing an area (such as lip, cheek, or tongue) that has received the local anesthetic.

D. Injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for several weeks, months, or rarely, be permanent.

E. Local anesthesia is administered with a very small, fine needle. In very rare instances these needles may break off and be lodged in soft tissue, which may require surgical retrieval.

Please ask the dentist or her assistant if you have any questions regarding this consent form. Do not initial or sign any blank if you have not had your questions answered.

I hereby acknowledge that I have read this document, and have discussed all questions or concerns that I might have regarding local anesthesia.

_____ _____

Patient or Guardian Signature Date

_____ _____

Doctor Signature Date

_____ _____

Witness Signature Date

Adopted 10/04/06

CHRISTINA P. MILLS, DDS

1701 Sunset Lane
Culpeper, VA 22701
PHONE (540) 825-1366….FAX (540) 825-9005
Email – tracy@drchristinamills.com

REQUEST TO RELEASE MEDICAL RECORDS

Patient's Name _____ Date _____

Date of Birth _____

Please release my medical records (circle To or From and fill in other DDS info):

To From To From

Christina Mills, DDS _____

1701 Sunset Lane _____

Culpeper, Va 22701 _____

E-Mail _____

Permanent transfer? (circle one) Yes No

Reason for transfer _____

_____

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Witness Signature Date

==========

OFFICE USE ONLY:

Approved by Dr. Mills _____ Date sent _____