RICHARD L. MULLER, JR., D.D.S.

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointment, or fees, please feel free to ask.

In order to safeguard your health, it is important that you answer the following questions. Please remember that the answers to these questions are held in strict confidence.

PATIENT INFORMATION

Patient Name_____ Today's Date _____

Soc. Sec. No._____ Age_____ Birthday_____

Home Phone_____ Work Phone_____ Cell _____

Home Address_____ City_____ State____ Zip_____

Marital Status_____ Name of Spouse/Parent_____ Referred by _____

RESPONSIBLE PARTY

Person Responsible For Account_____ Relationship to Patient _____

Address_____ Home Phone _____

Driver's Lic. No._____ Birthday_____ Soc. Sec. No. _____

Is this person currently a patient in our office? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient _____

Birthday_____ Soc. Sec. No. _____

Name of Employer_____ Work Phone _____

Insurance Company_____ Group No._____ Union or Local No. _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Richard L. Muller, Jr., DDS, PC

2236 Redmond Circle N.W./Rome, GA 30165-2026/706-295-7385

Written Financial Policy

Thank you for choosing Richard L. Muller, Jr., DDS, PC. Our primary mission is to deliver the best and most comprehensive dental care available. We will do our very best to make your time with us as pleasant as possible. We will make every attempt to seat you at your appointed time. However, emergencies do throw the schedule behind. Your patience is appreciated.

An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Visa, MasterCard, American Express, Discover Card, Cash or Check
- No Interest Payment Plans from CareCredit
    - Allow you to pay over time with No Interest. (If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. Subject to credit approval.)
    - No annual fees or pre-payment penalties.

Please note:

Richard L. Muller Jr., DDS, PC requires payment when services are rendered.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit, directly bill them for reimbursement for your treatment and collect your co-pay at time of service; however, you are responsible for any balance unpaid by your insurance. **Our office does not participate in any network programs.**

Patients who miss or cancel more than 3 times in a calendar year, without a 24-hour notice, may be dismissed from our practice.

Richard L. Muller, Jr., DDS, PC charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

Richard L. Muller, Jr., DDS, PC

2236 Redmond Circle NW | ROME GA, 30165 | (706)295-7385
drrichardmuller@bellsouth.net

Dental Treatment Consent Form

For your convenience, we make available this generalized dental consent form for your review and signature. Please do not hesitate to ask our dental staff any questions you may have.

1. Drugs and Medications
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

2. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

3. Removal of Teeth
If the teeth are savable/restorable, the alternatives to removal of teeth are root canal therapy, crowns, and periodontal surgery, etc. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) of fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

4. Crown, Bridges and Caps
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown, which my come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

5. Dentures, Complete or Partial
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances include looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

6. Endodontic Treatment (Root Canal)
I realize there is not guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

7. Periodontal Loss (Tissue and Bone)
I understand that serious gum problems can lead to bone infection or bone loss and that it can lead to the loss of my teeth. Alternative treatments include gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself of my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Parent or Guardian **Relationship** **Date**

RICHARD L. MULLER, JR., D.D.S., P.C.

MEDICAL HISTORY FORM

Date: _____ Name: _____ Age: _____

Address: _____ Telephone: _____

Sex: _____ Marital Status: _____ Weight: _____ Height: _____

Physician's Name: _____ Telephone: _____

DIRECTIONS:

Answer all questions by circling either YES or NO and fill in the blank spaces to the best of your ability. If you don't understand a question, consult your dentist. All information will be considered confidential.

1. Date of your last physical examination: _____
2. Have you been hospitalized or had a serious illness within the last 3 years? ..... YES NO
   If so, what was the problem? _____
3. Are you under the care of a physician? ..... YES NO
   If so, for what condition? _____
4. Do you have or have you had any of the following diseases or problems:

A. **CARDIOVASCULAR**

1) Rheumatic Fever ..... YES NO
2) Congenital Heart Defect – type: _____ surgery date: _____ ..... YES NO
3) Angina Pectoris – frequency: _____ ..... YES NO
4) Myocardial Infarction (Heart Attack) – date: _____ ..... YES NO
5) Arrhythmias (Irregular Beat) – type: _____ ..... YES NO
6) Cardiac Murmur – etiology (cause): _____ ..... YES NO
7) Congestive Heart Failure – date: _____ ..... YES NO
8) Heart Surgery – type: _____ date: _____ ..... YES NO
9) Pacemaker Implanted – type: _____ date: _____ ..... YES NO
10) Hypertension (High Blood Pressure) – BP: ____/____ ..... YES NO
11) Hypotension (Low Blood Pressure) – BP: ____/____ ..... YES NO
12) Stroke (CVA) – date: _____ ..... YES NO

B. **RESPIRATORY DISEASES**

1) Asthma – severity: _____ ..... YES NO
2) Emphysema – severity: _____ ..... YES NO
3) Bronchitis – severity: _____ ..... YES NO
4) Hay Fever or Sinusitis ..... YES NO

C. **ENDOCRINE DISORDERS**

1) Diabetes – type control: _____ ..... YES NO
2) Hyperthyroidism (High Thyroid) – treatment: _____ ..... YES NO
3) Hypothyroidism (Low Thyroid) – treatment: _____ ..... YES NO

D. **HEMATOLOGIC (BLOOD) DISORDERS**

1) Anemia – type: _____ ..... YES NO
2) Bleeding Tendency – Do you bruise or bleed excessively when cut? ..... YES NO
   Explain: _____

E. **PSYCHIATRIC PROBLEMS**

1) Are you presently seeing or have you seen a psychiatrist in the last 3 years? ..... YES NO
   Physician: _____ Telephone: _____
   _____

F. **INFECTIOUS DISEASE**

1) Hepatitis – type: _____ date: _____ ..... YES NO
2) Venereal Disease – type: _____ date: _____ ..... YES NO
3) Tuberculosis – date: _____ ..... YES NO
4) A.I.D.S. (Acquired Immune Deficiency Syndrome) – date: _____ ..... YES NO
5) HIV Positive – date: _____ ..... YES NO

(Complete reverse side)

G. **RENAL (KIDNEY) DISEASE**

1) Have you had any kidney infections within the last 3 years? ..... YES NO
type: _____ date: _____

2) Have you had any kidney surgery? type: _____ date: _____ ..... YES NO

H. **MISCELLANEOUS DISEASES OR DISORDERS**

1) Syncope (Fainting) -- frequency: _____ ..... YES NO
2) Liver Disease -- type: _____ ..... YES NO
3) Arthritis -- type: _____ ..... YES NO
4) Ulcers -- type: _____ ..... YES NO
5) Glaucoma: _____ ..... YES NO
6) Radiation Therapy -- type: _____ date: _____ ..... YES NO
7) Epilepsy -- treatment: _____ ..... YES NO
8) Have you had cancer? -- type: _____ date: _____ ..... YES NO
9) Do you use tobacco? -- type: _____ ..... YES NO

5. Are you taking any of the following medications:

A. Antibiotics (etc.) -- type: _____ amount: _____ ..... YES NO
B. Anticoagulants (Blood Thinners) ..... YES NO
C. Steroids (Cortisone) -- type: _____ amount: _____ ..... YES NO
D. High Blood Pressure Medicine -- type: _____ amount: _____ ..... YES NO
E. Tranquilizers -- type: _____ amount: _____ ..... YES NO
F. Aspirin -- how often: _____ ..... YES NO

Others:	Drug	Amount	How Often
G.			
H.			

6. Do you have an allergy or reaction to:

A. Local Anesthetics -- type: _____ reaction: _____ ..... YES NO
B. Penicillin or Antibiotics -- type: _____ reaction: _____ ..... YES NO
C. Sulfa Drugs -- reaction: _____ ..... YES NO
D. Aspirin -- reaction: _____ ..... YES NO
E. Barbiturates or Other Sedatives -- type: _____ reaction: _____ ..... YES NO

Others:	Drug	Reactions
F.		

7. Have you had difficulty with any dental treatment including extractions? ..... YES NO
If so, explain: _____

8. Do you have any problem or condition not listed above? ..... YES NO
If so, explain: _____

9. **WOMEN ONLY**

1) Are you pregnant? -- scheduled delivery: _____ ..... YES NO
2) Do you have menstrual difficulty? -- type: _____ ..... YES NO

BP ____/____ Temp. _____ Pulse _____ Resp. _____/ min

Remarks:

Date Reviewed	**Initialed**

_____
Signature of Patient

_____
Signature of Dentist