Patient Information

Patient Name:_____ Today's Date: _____
Last First MI (Preferred Name)

Is Patient a child/dependent ☐ Yes ☐ No ☐ Male ☐ Female Married? ☐ Yes ☐ No

Social Security #: _____ Birth Date: _____ Email: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street Apartment#

_____
City State Zip Code

Employer Name: _____

How did you hear about us? _____

Health Information

Date of Last Dental Visit:_____ Reason for today's visit: _____
Height: _____ Weight: _____ Date of Last Physical: _____

Have you ever been diagnosed with any of the following? (Please check all that apply):

☐ AIDS/HIV	☐ High Cholesterol	☐ Jaundice/Liver Disease	☐ Sinus Problems
☐ Allergies	☐ Diabetes	☐ Joint Replacement	☐ Stomach Problems/Ulcers
☐ Anemia	☐ Dizziness/Syncope	☐ Kidney Disease	☐ Stroke
☐ Arthritis	☐ Epilepsy/Seizures	☐ Latex Allergy	☐ St. John's Wort used
☐ Artificial Joints	☐ Pre-medication	☐ Psychiatric Disorder	☐ Tuberculosis
☐ Asthma/ Respiratory Problems	☐ Epinephrine Allergy	☐ Nervous Disorders	☐ Tumors
	☐ Blood Disorder	☐ Glaucoma	☐ Pacemaker
☐ Thyroid Problems	☐ Cancer	☐ Growths/Tumors	☐ Currently or Possibly Pregnant
☐ Venereal Disease	☐ Drink Grapefruit Juice	☐ Drug/Alcohol Abuse	
☐ Tobacco Use	☐ Smokeless Tobacco Use	☐ Head Injuries	☐ Trying to conceive?
☐ Heart Murmur	☐ Hepatitis A/B/C	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Heart Disease	☐ Radiation Treatment	☐ Rheumatic Fever	☐ Cold Sores/Fever Blisters

☐ List of current medications:

_____

_____

☐ List any/all ALLERGIES to medications:

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Consent For Services

(Please read this section carefully and sign the bottom)

I voluntarily and knowingly request and consent to services, treatments and/or procedures recommended by McMillan Sedation Dentistry and to all diagnostic methods deemed appropriate by McMillan Sedation Dentistry, which may include, but not limited to, x-rays, study models, imagery and other aids. I authorize McMillan Sedation Dentistry to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that McMillan Sedation Dentistry may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by McMillan Sedation Dentistry. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge I am fully responsible for the payment of all sums owed to McMillan Sedation Dentistry for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, McMillan Sedation Dentistry will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by McMillan Sedation Dentistry. I acknowledge that it is my responsibility to provide McMillan Sedation Dentistry with my current insurance information and any changes thereto.

I understand that if, for any reason other than traumatic accident or patient non-compliance, my restorations fail or break, they will be replaced by the dental office of McMillan Sedation Dentistry for laboratory fees for the first two years following the permanent placement. After the completion of the first full two years following the initial treatment, I will be responsible for sixty percent (60%) of the current replacement fee, eighty percent (80%) after three full years and the total cost (100%) after 5 complete years. I understand that the warranty work ***must*** be performed by the office of McMillan Sedation Dentistry in order to comply with the terms of my warranty.

I understand that in order to initiate my warranty, it is my responsibility to complete all recommended restorative treatment and follow recommended maintenance schedules, including and not limited to hygiene appointments, post-operative home care, post-op appointments, delivery of permanent restorations and prosthetics, and custom occlusal guard protection and that this treatment must be performed at the dental office of McMillan Sedation Dentistry. If my treatment and maintenance plans are not followed as recommended, and/or appointments are missed, adverse results could affect my dental health and insurance coverage. If I do not proceed with my recommended treatment plan in a timely manner, I understand that I could risk requiring further treatment for the involved teeth, supportive tissues, adjacent and opposing teeth, and/or muscles or joints; and upon such circumstance, any warranty may be revoked at the doctor's sole discretion.

I understand that this office reserves the right to charge a cancellation fee of $150 per hour in the event that I fail to appear and/or give ***2 full business days*** **notice** to reschedule or cancel any **hygiene appointment**. I understand that this office reserves the right to charge a cancellation fee of $250 per hour in the event that I fail to appear and/or give ***2 full business days*** **notice** to reschedule or cancel any **appointment with Dr. McMillan**. Exceptions will be made at the doctor's sole discretion for circumstances related to or involving true medical emergency or death in the family. I further understand that my cancellation fee must be paid prior to scheduling any additional or future appointments on my or my family's behalf. This office will make every reasonable effort to remind me of my scheduled appointments; however, I agree and understand that it is my responsibility to remember and attend my appointments.

I understand that fee estimates can only be extended for a period of 30 days from the date of the patient examination.

I consent to McMillan Sedation Dentistry's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all the insurance benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company to make payment directly to McMillan Sedation Dentistry for the costs associated therewith.

McMillan Sedation Dentistry

Authorization for Release of Information – Compound Release

Patient Name:

Patient Date of Birth:

The office of McMillan Sedation Dentistry is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on** _____ **number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

_____

Signature of Patient or Personal Representative Date:

Description of Personal Representative's Authority (attach necessary documentation) :

☐ Mother ☐ Father ☐ Legal Guardian

Date this Authorization Expires: _____

McMillan Sedation Dentistry

Authorization for Release of Information – Media

Patient Name:

Patient Date of Birth:

McMillan Sedation Dentistry is authorized to release protected health information as described below for the identified patient.

Use still, audio and video images with my likeness for the purposes of (Check all that Apply):

- ☐ **Facebook**
- ☐ **Instagram**
- ☐ **Twitter**
- ☐ **Practice Website**
- ☐ **Advertising**
- ☐ **Before and After Photos**
- ☐ **Posted/Streamed in Office**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation) :

☐ Mother ☐ Father ☐ Legal Guardian

Date this Authorization Expires: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice, please contact the Privacy Officer.

6035 Burke Centre Parkway
Suite 330
Burke, VA 22015
703-503-9490

Effective Date: April 2003 **Revised: July 21, 2019**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: https://www.mcmillansedationdentistry.com/

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.

- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights, or you have a complaint about our privacy practices you can contact:

6035 Burke Centre Parkway
Suite 330
Burke, VA 22015
703-503-9490

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us:

Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102

If you file a complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 2003

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address:

I have received a copy of the Notice of Privacy Practices from the practice.

Signature	Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

- ❑ Other:

Prepared by:	
Signature:	
Date:	

McMillan Sedation Dentistry

Authorization for Release of Information – Media

Patient Name:

Patient Date of Birth:

McMillan Sedation Dentistry is authorized to release protected health information as described below for the identified patient.

Use still, audio and video images with my likeness for the purposes of (Check all that Apply):

- ☐ **Facebook**
- ☐ **Instagram**
- ☐ **Twitter**
- ☐ **Practice Website**
- ☐ **Advertising**
- ☐ **Before and After Photos**
- ☐ **Posted/Streamed in Office**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation) :

☐ Mother ☐ Father ☐ Legal Guardian

Date this Authorization Expires: _____