Advanced Concepts In General Dentistry

The Center For TMJ & Neuromuscular Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I (print your name)______________________________________
have been provided Dr. David B Miller's Notice of Privacy Practices.

*You may refuse to sign this acknowledgement

SIGNATURE____ DATE ____________________

Emailing X-Rays

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentist. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker services.

I understand the x-rays might need to be e-mailed to other specialists and dentists. I give my permission for this service.

SIGNATURE____________________________(Relationship)________________DATE____________

Personal Health Information Disclosure Agreement

I ________________________________, grant permission for Dr. David B Miller's Office, to disclose my personal health information to the following personal representative(s): (spouse, sibling, parent, child, friend, etc.) ____

____

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Information to be disclosed (please check):

- o Appointment dates and times
- o Treatment plans and referrals
- o Financial and billing information
- o Any other pertinent dental health information related to related to treatment at this office
- o None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Dr. David B. Miller's Office.

SIGNATURE____ DATE ____________________

DAVID B. MILLER DDS
a Professional Corporation

Master, Academy of General Dentistry
Fellow, American Orthodontic Society
Fellow, Int'l College of Oral Implantology
Diplomate, American Academy of Craniofacial Pain
Diplomate, American Academy of Pain Management
Diplomate, American Board of Orofacial Pain
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