Brad M. Mills
DMD MS
ORTHODONTICS

Welcome to Dr. Brad Mills!

PATIENT INFORMATION

Name _____ Address _____
(First) (M.I.) (Last)
Name you go by _____ City _____ State ___ Zip _____
Phone (Home) _____ Social Security # _____
Phone (Work or Cell) _____ Status (circle) Minor Single Married Partnered
Birthdate _____ Sex: M / F *(circle)*

RESPONSIBLE PARTY INFORMATION

Name _____ Social Security # _____
Name you go by _____ Birthdate _____
Phone (Home) _____ Place of employment _____
Phone (Cell) _____ Phone(Work) _____
Cell Phone Carrier _____
Relation to Patient _____
Address (if different than Patient) _____ City _____ State _____ Zip _____
E-Mail (*one checked often*) _____
Marital Status (please circle) Single Married Divorced Widowed Partnered

Spouse/Partner _____
Spouse's Place of Employment _____
Spouse Phone(Work) _____ Spouse Phone(Cell) _____
Spouse's Social Security # _____ Spouse's Birthdate _____

EMERGENCY CONTACT(Someone that lives outside the household)

Name _____ Phone _____

Are there any other family members that are patients here? *yes / no (circle) Who?* _____

Whom May We Thank For Referring You?/Who told you about us?
Name _____ Address _____ Phone _____

MURRAY
1708 121 By-Pass North
Murray, Kentucky 42071

PADUCAH
3435 Lone Oak Road
Paducah, Kentucky 42003
Phone 270-554-1993
Fax 270-554-2019

MAYFIELD
212 North 7th Street
Mayfield, Kentucky 42066

(OVER)

INSURANCE INFORMATION (ORTHODONTIC INSURANCE ONLY)

Insured member's name_____
Insurance Carrier _____
Insurance Carrier's Phone Number _____
Insured member's ID #/SS #_____
Insured member's Birthdate_____
Employer_____
Employer address_____

AUTHORIZATION AND RELEASE

I hereby authorize Dr. Brad Mills and/or Staff to release medical information as needed. I also give authorization to file insurance claims and assign benefits. For purposes of payment options, authorization is given to obtain a copy of my credit report and/or rating.

X_____

Signature of Responsible Party Date

DENTAL HISTORY

General Dentist_____ Phone_____
Date of last dental visit _____ Date of last dental X-rays_____

MEDICAL HISTORY

Have you had any serious illnesses or operation? ___Yes ___No
If yes, describe _____
Have you ever had a blood transfusion? ___Yes ___No If yes, when_____
(Women) Are you pregnant? __Yes __No

Have you ever had any reactions to LATEX? *Yes / No (circle one)*

Check (X) if you have had any of the following:

__AIDS	__Cortisone treatments	__Hepatitis	__Rheumatic Fever
__Anemia	__Cough, persistent	__High blood pressure	__Scarlet Fever
__Arthritis	__Cough up blood	__HIV Positive	__Shortness of breath
__Artificial Heart Valves	__Diabetes	__Jaw Pain	__Skin Rash
__Asthma	__Epilepsy	__Kidney Disease	__Stroke
__ADD/ADHD	__Fainting	__Liver Disease	__Swelling of feet
__Back problems	__Glaucoma	__Mitral Valve Prolapse	__Thyroid Problems
__Blood Disease	__Headaches	__Nervous Problems	__Tobacco Habit
__Cancer	__Heart Murmur	__Psychiatric Care	__Tuberculosis
__Chemical dependency	__Heart Problems	__Pacemaker	__Tonsillitis
__Chemotherapy	_____	__Radiation treatment	__Ulcer
__Circulatory Problems	__Hemophilia	__Respiratory Disease	__Venereal Disease

MEDICATIONS
List medications you are currently taking:
_____
_____

ALLERGIES
List all allergies:
_____
_____

FOR OFFICE USE ONLY

*Treatment*_____
_____
_____
_____

DR. BRAD S. MILLS, D.M.D., M.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME_____

ADDRESS_____PHONE_____

E-mail_____ SOCIAL SECURITY NUMBER_____

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. This form also gives us the right to use the patient's name, photos, birth date, etc. for use in our office for advertising and marketing and on our billboard signs.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations. A copy of our Notice accompanies this Consent. 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:
DR. BRAD S. MILLS, D.M.D., M.S.
3435 LONE OAK ROAD, PADUCAH, KY 42003
270-554-1993

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 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 you revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 to carry out treatment, payment activities and health care operations. I also give authorization to this office to use my name, date of birth and photo for advertising, marketing, internet, and a marquee sign. I also give permission to contact any third party payers and responsible parties in connection with this patient's financial and medical information in an effort to complete this patient's care and collect all debts. I have received the Notice of Privacy Practices for this office.

If RECORDS, an X-ray, impressions for study models, and diagnostic photos, are done and the patient does not follow through with orthodontic treatment, a $200.00 fee will be charged. If INVISALIGN RECORDS are done and the patient does not proceed with orthodontic treatment a $500.00 fee may be imposed.

Adult, Parent, Guardian or Personal Representative
Signature: _____Date:_____

Relationship to Patient: _____

WE WANT YOU TO KNOW ABOUT INFORMED CONSENT

for the Orthodontic Treatment of_____

In the vast majority of Orthodontic cases, significant improvements can be achieved. While the benefits of a pleasing smile, face and health dentition are widely appreciated, Orthodontic Treatment remains an elective procedure. Orthodontics, like any other treatment of the body, has some inherent risks and limitations. These are seldom that serious as to contraindicate Orthodontics, but should be considered in making the decision to undergo risk and limitations, ask us any questions that may come to mind, then (after you are completely satisfied with our explanations) consent to our treating you or your child by signing this form.

PATIENT COOPERATION-THE MOST IMPORTANT FACTOR IN COMPLETING TREATMENT ON TIME.
The sufficient wearing of elastics, removable appliances, headgear or neck straps; broken appliances, and missing appointments, prevent our obtaining the desirable jaw growth anticipated. These are the factors which can lengthen treatment time and adversely affect the quality of treatment results.

DECALCIFICATION-TOOTH DISCOLORATION.
The avoidance of chewing hard/ sticky foods will keep bands and brackets from loosening. This and the reduction of sugar intake, and reporting any loose bands as soon as they are noticed, will help minimize decay and gum problems. It is important to brush your teeth and gums immediately after eating. This will help prevent decalcification, the white, soft enamel areas that can become decayed.

NONVITAL TOOTH-USUALLY THE RESULT OF AN INJURED TOOTH.
An injured tooth can die over a period of time with or without Orthodontic treatment. This tooth may flare up during Orthodontic movement and would require root canal treatment. Such discoloration of a tooth may be noticed after treatment has started or following appliance removal. Devitalization is seldom due to Orthodontics.

NECK STRAP OR HEADGEAR RETRACTION-INSTRUCTIONS MUST BE FOLLOWED CAREFULLY.
Safety devices have been developed and are being used, but there is currently no foolproof device if the patient is careless; if a bow-arch is pulled out while the elastic force is attached, it can snap back and cause injury.

ROOT RESORPTION-SHORTENING OF ROOT ENDS.
This can occur with or without Orthodontic Treatment. Under healthy conditions the shortened roots are usually no problem. Injury, impaction, endocrine or idiopathic disorders can be responsible.

TEMPRO-MANDIBULAR JOINTS (TMJ)-THE SLIDING HINGE CONNECTING THE UPPER/LOWER JAWS
Possible problems may exist or occur during the following Orthodontic Treatment. Tooth position and bite can be a factor in this condition. An equilibration by your dentist may be recommended after appliances are removed to improve occulsal relationship. TMJ problems are not all "bite" related. Remember that most individuals have never had Orthodontic Treatment.

GROWTH PATTERNS-FACIAL GROWTH OCCURING DURING OR AFTER TREATMENT.
Uncorrected finger, thumb, tongue or similar pressure habits, usually hereditary skeletal patterns, insufficient or undesirable growth can all influence our results, effect facial change and cause shifting of teeth during or following retention. Surgical procedures can frequently correct these problems. On rare occasions it may be necessary to recommend a change in our original treatment plan.

RELAPSE-MOVEMENT OF TEETH FOLLOWING TREATMENT.
Settling or shifting of teeth following treatment as well as after retention will most likely occur in varying degrees. Some of these angles may or may not be desirable. Rotations and crowding of lower anterior teeth are most common examples. Slight spaces in extraction sites or between some upper anterior teeth are other examples. Sometimes we might advise the retaining appliance every night or a few evenings each week for an indefinite period.

PERIODONTAL PROBLEMS-GUM INFLAMMATION BLEEDING AND PERIODONTAL DISEASE.
Swollen, inflamed, and bleeding gums can usually be prevented by proper and regular flossing and brushing. Periodontal disease can be caused by accumulation or plaque and debris around the teeth and gums, but there are several unknown causes that can lead to progressive loss of supporting bone and recession of gums. Should the condition become uncontrollable, Orthodontic Treatment may have to be discontinued short of completion. This would be rare, usually in adults with a pre-existing periodontal problem.

UNUSUAL OCCURENCES.
Swallowing of an appliance, chipping of a tooth, dislodging a restoration; anllylosed tooth, an abscess or cyst may occur but these are rare.

DENTAL CHECK-UPS.
All necessary dentistry must be completed prior to our starting Orthodontic therapy. It is essential that the patient maintain their regular examinations with their family dentist every six months during the treatment period. Adults must visit their dentist, hygienist, or Periodentist for sealing and cleaning every three to five months while being treated.

Again, it is our intent to inform you of the myriad of possibilities that exist as potential problems. Most of these conditions rarely occur. There may be other inherent risks not mentioned. You should be aware that all of these things could happen. If any of these conditions should develop, every effort will be made to refer the patient to the appropriate therapist. Treatment of human biologic conditions will never reach a state of perfection despite technological advancement. Your treatment depends on a close professional working relationship. Patients should feel free to inquire about any aspect of their treatment.

I CONSENT TO THE TAKING OF PHOTGRAPHS & X-RAYS DURING AND AFTER THE TREATMENT, AND TO THE USE OF THEM BY THE DOCTOR IN SCIENTIFIC PAPERS OR DEMONSTRATIONS.

THERE IS A $25 DOLLAR CHARGE FOR ALL NO SHOW APPOINTMENTS. PLEASE GIVE THE OFFICE A 24 HOUR NOTICE IF YOU NEED TO CANCEL OR RESCHEDULE AN APPOINTMENT.

I CERTIFY THAT I HAVE READ OR HAVE HAD READ TO ME THE CONTENTS OF THIS FORM AND DO REALIZE THE RISKS&LIMITATIONS INVOLVED & DO CONSENT TO ORTHODONTIC TREATMENT.

_____
Patient/Parent/Guardian

_____
Date

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify)

Dr. Brad S Mills Orthodontics

Directions to our offices:

Our **Lone Oak** office is located at 3435 Lone Oak Road.

From I-24, get off on exit 7, go south on Lone Oak Road, passing K-Mart, Supervalu, Hardee's, and Wendy's. Our office is located on the right across the road from the Dollar General Store.

From Mayfield, on Highway 45, pass Grover Tire, The Smoke Shop, St. Johns, and The Buckstop Gas Station/The P.A.C., we are located on the left across from the Dollar General. *Patients are seen in this location on Tuesday and Thursday.*

Our **Murray** office is located at 1708 Bypass North.

From 641, turn onto Highway 121 across from JC Penney. Go thru two traffic lights (approx. ¼ to ½ mile). Our office is located on the right just past Farm Bureau Insurance, beside of the Northpoint Building. *Patients are seen in this location on Monday and Friday.*

Our **Mayfield** office is located at 212 North 7th Street.

Our office is located right off of the court square. Turn onto 7th Street (as if you're going to Paducah). Our office will be on your right.

If you are coming from Lone oak, you will stay on Highway 45 for approximately 20 miles. When you get into town, turn left on West North Street, take the first left onto North 7th Street/US 45 North (You are now on the one way street that goes back to Paducah. We are on the right, past Regions Bank, across from Dennis Null's office. We share an office with Dr. Jerry Mills.

If you are coming from Murray, come into Mayfield on KY 121/Highway 80. Drive approximately 20 miles. Stay on 121. Take 1st right on North 7th. If you reach East Anne's Street you have went too far.
Patients are seen in this location every other Tuesday.

If you have problems locating any of our offices, please feel free to call us @ (270)554-1993

Keep this paper.

Tell Us About You!

Name:_____

Nickname:_____

Age:_____

What School do you go to? _____

What grade?_____

Do you have any siblings? YES NO

Brothers?_____ Sisters?_____

What are your hobbies?

_____

_____

Do you play any sports?_____

Do you have any pets?_____