Jonathan M. Miller, DDS
112 W. Saint John St
Tarboro, NC 27886
252.823.3864

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____(Work): _____(Other):_____

E-Mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer's Name/Adress_____

_____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address:

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Other):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Insurance Carrier ☐ Website ☐ Magazine ☐ Office Sign ☐ Other_____

Name of person or office referring you to our practice:_____

_____

Dental History

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Date of Last Dental Visit: _____Name of previous dentist: _____

- Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

Do you presently or have ever had any of the following:

☐ Clinching or grinding	☐ Jaw pops or clicks
☐ Pain in or around ear	☐ Frequent headaches
☐ Difficulty opening/Closing	☐ Bleeding gums
☐ Gum Surgery	☐ Previous Periodontal Treatment
☐ Bad dental experience	☐ Had immediate relative lose all their natural teeth

- Are your teeth sensitive to : ☐ Hot ☐ Cold ☐ Biting ☐ Sweets
- Are you happy with the appearance of your teeth? ☐ Yes ☐ No

How often do you FLOSS? _____ How often do you BRUSH? _____

Problem or reason for coming in today:_____

Consent for Services

This is to certify that I, undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated.

The above information is accurate to the best of my knowledge. All changes to my health will be reported to this office at the following appointment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I assign any and all dental insurance benefits due to me for treatment rendered to this Jonathan M. Miller, DDS.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the stated value of said services to said Doctor, or his assignee, at the time services are rendered. I further agree that the reasonable value of said services shall be as agreed to before treatment was rendered.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form or dental services performed or planned.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments or cancelling with less than 24 hours notice - $50.00*. Repeated cancellations or missed appointments will result in loss of future appointment privileges.*

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We make every effort to be prompt! We, of course, would appreciate the same courtesy from you.

Signature of Patient, Parent or Guardian; _____

Records Consent

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

- Send pertinent information to other dentists or doctors to whom I may be referred for care, including my name, address, telephone number, social security number and date of birth.
- Disclose my dental information to my dental insurance company as needed for my insurance claims
- Transfer copies of my dental record to another dentist upon my written request.
- Contact normal health care operations such as quality assessments and physical certifications.

I understand that I may request a complete copy of Jonathan M. Miller, DDS, PA Notice of Privacy Practices.

Signature of Patient, Parent or Guardian: _____