DR. J. ANDREW MILLER DMD

1120 HIGH ST STE A, BRANDENBURG KY 40108

270-422-4921

PATIENT INFORMATION **DATE:_____**

First Name:_____ Preferred Name:_____

Middle Name:_____ **Male Female**

Last Name:_____ **Married Single Child**

DOB_____ SSN_____

HOME:_____CELL:_____WORK_____

Mailing Address_____

Email:_____

Emergency Contact:_____

EMPLOYER_____Occupation_____

Address_____Phone_____

(child only) Parent/Guardian_____

Address(if different)_____

Contact phone#'s CELL_____HOME_____WORK_____

Due to privacy practices, all information is confidential. Please list anyone we may share your dental information with. (Example..Appointment time, treatement needed, fees, etc)

NAME	RELATIONSHIP	PHONE#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Dental Insurance

Insurance Company_____ID#_____DOB_____

Relationship to Patient_____Ins Phone#_____

Secondary Insurance

Insurance Company_____ID#_____DOB_____

Relationship to Patient_____Ins Phone#_____

Assignment & Release

I, the undersigned, assign directly to Dr. Miller all benefits, if any, otherwise payable to me for dental services rendered. I hereby authorize Dr. Miller to release any/all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions whether manual or electronic.

Signature_____Date_____

DR. J. ANDREW MILLER DMD

1120 HIGH ST STE A, BRANDENBURG KY 40108

270-422-4921

NAME:_____

Primary Care Physician_____Phone_____

Pharmacy_____Phone_____

Do you have, or have you ever had, any of the following : (please circle **Y** (yes) or **N** (no))

Y	N	Anemia	Y	N	Blood Disease	Y	N	Arthritis
Y	N	Artificial Joints	Y	N	Asthma	Y	N	Respiratory Disease
Y	N	Cancer	Y	N	Chemo/Radiation	Y	N	Circulatory Problems
Y	N	High Blood Pressure	Y	N	Heart Problems	Y	N	Artificial Valve/Pacemaker
Y	N	Epilepsy	Y	N	Seizures	Y	N	Immune Compromised
Y	N	HIV Positive	Y	N	Kidney Disease	Y	N	Diabetes
Y	N	Hepatitis	Y	N	Liver Disease	Y	N	Anxiety/Depression
Y	N	ADD or ADHD	Y	N	Neurological Disorder	Y	N	Stroke
Y	N	Multiple Sclerosis	Y	N	Parkinsons	Y	N	Thyroid problems
Y	N	Tobacco use	Y	N	Recreational Drugs	Y	N	Ulcers or Reflux

PLEASE LIST

Allergies:

_____

_____

_____

Current Medications(vitamins, herbs, patches etc):

_____

_____

Surgeries:

_____

_____

Other:_____

DR. J. ANDREW MILLER DMD
1120 HIGH ST STE A, BRANDENBURG KY 40108
270-422-4921

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

Consent

I hereby authorize Dr. Miller and/or dental staff to take x-rays, photographs or any other diagnostic aid deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor and/or dental staff to perform any/all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.

Timeliness is required. I understand that two business day notice is required if I cannot keep an appointment. **I understand I will be charged a $35.00 fee for each missed appointment if notice is not given. I am aware that my insurance does not cover missed appointment fees.**

I understand that the portion of my dental treatment not covered by my dental insurance is due and payable each visit. My insurance is a contract between the insurance carrier and myself. I understand that the responsibility for payment for dental services provided in this office is mine; due and payable at the time services are rendered unless financial arrangements have been made. If the balance is not paid within thirty (30) days of the date of service, a service charge will be added to my account for the current monthly billing period. The service charge will be at a periodic rate of 1.5% per month or an annual rate of 18%.

I agree to reimburse J. Andrew Miller, D.M.D. the collection fees of any collection agency which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time my account is placed with a collection agency and all costs and expenses incurred for any collection efforts on my account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all dental treatment and services until revoked by either party in writing.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my patient, insurance and/or health information.

Signature _____ Date _____

*****For Office Use Only*****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: _____individual refused to sign _____communication barriers prohibited the acknowledgement _____an emergency situation prevented us from obtaining acknowledgement or (other) _____.