Cary S. Miller, D.M.D., P.C.
349 Madison St.
Clarkesville, GA 30523

PATIENT INFORMATION

Date:_________________

Name:_____________________________Birthdate:_____________ Male☐ Female☐
Last First M.I.

Address: ____
Street City State zip code

Home phone number:_______________Work #________________ Cell#____________

Email Address:__________________________________

When and Where is the best time and place to reach you?___________________☐

New Patients please provide your photo ID

Employer_________________________ Address: ________________________

Occupation:__________________

Married_____if yes, Spouse's Name:____________________________Single______Widowed______

Who may we thank for referring you?_____________________________________

Other family members seen at this office___________________________________

*Pharmacy:*_____________________

In case of emergency, who should we contact?______________phone #____________________

Person Responsible for Account:____
Last name First Name M.I.

Relationship to patient: ________ Birthdate:_____________ Soc.Sec.#_____________

Signature of responsible party: ________________________________

Previous/Present Dentist_________________________Date of last visit___________

Personal Physician______________Phone #_________________last visit_________

Current medications taken____

***For women**: are you pregnant? Yes☐ No☐ Week #:______Nursing? Yes☐ No☐*

DENTAL INSURANCE

Insurance Co. Name: _________________________ Employer_________________

Subscriber's Name:_____________________Birthdate:______________________

Soc.Sec.#:_______________ Group #______________ I.D.#____________________

Insurance Co. phone #_________________Address:_________________________

***Do you have secondary insurance*? Yes☐ No☐ If yes, please complete:**

Insurance Co. Name: _________________________ Employer_________________

Subscriber's Name:_____________________Birthdate:______________________

Soc.Sec.#:_______________ Group #______________ I.D.#____________________

Insurance Co. phone #_________________Address:_________________________

↓↓(please see other side)↓

MEDICAL HISTORY

Please check all that apply:

Heart Attack/Surgery..☐ Stroke……………… ☐ Cancer………………….☐
Heart Murmur………☐ Rheumatic fever….. ☐HIV/AIDS……………..☐
Artificial heart valve…☐ Shingles………….. ☐ Kidney problems……….☐
Mitral valve prolapse..☐ Joint replacement surgery☐/date__________
Fever blisters…………☐Psychiatric problems.☐ Epilepsy/Seizures……….☐
Diabetes……………...☐ Tuberculosis…………☐ Drug/Alcohol abuse…….☐
Hemophilia…………..☐Ulcers/Colitis……….☐ Congenital heart defect...☐
Anemia……………….☐ Arthritis…………….☐ Asthma………………….☐
Hepatitis……………..☐ Blood Transfusion……☐ Emphysema…………….☐
Glaucoma……………☐ High/Low blood press. ☐

Have you ever been told by a physician that you need antibiotics prior to dental treatment?yes___no___

Allergies:

Penicillin……………☐ Codeine ………..☐Latex……………...☐
Dental anesthetics…..☐ Aspirin………………☐ Tetracycline……….☐
Other_______________________________________

I understand that I am financially responsible for all charges, whether or not they are rendered on my behalf or my dependents, and whether or not I have insurance coverage.

I hereby authorize payment directly to Cary S. Miller, DMD PC for all insurance services rendered.

I am responsible for payment of my account regardless of what my insurance pays and am responsible for knowing my dental benefits and plan frequencies.

I understand that any unpaid balance over 60 days old will be subject to monthly interest of 1.5% (APR 18%). This will include any unpaid balances already on my account, or any balance going forward from today. If full payment cannot be made for balances over 60 days, I understand that I should contact the office to work out a payment plan, which shall include a minimum payment due of 20%.

Any delinquent accounts may be sent to a collection agency, and I will be responsible for all fees incurred by the collection agency for my account. I authorize the use of my signature to collect fees for these services.

I understand that it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____-Please sign