Bruce
Williamson
Miller DDS PA
Restorative, Cosmetic & Family Dentistry

3100 Pineridge Lane (Off Union Road) Gastonia, NC 28056, Phone: (704) 864-2608 Fax: (704) 864-2609

Welcome!

Please take a few minutes to answer the following questions
so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____ Occupation _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

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Dental History

Former Dentist _____ Date of Last X-Rays _____

City. State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath	☐	Loose Teeth or Broken Fillings	☐	Sensitivity to Sweets	☐
Bleeding Gums	☐	Orthodontic Treatment	☐	Sensitivity When Biting	☐
Blisters on Lips or Mouth	☐	Pain Around Ear	☐	Frequent Headaches	☐
Finger Nail Biting	☐	Periodontal Treatment	☐	Jaw, Head or Neck Injuries	☐
Grinding Teeth	☐	Sensitivity to Cold	☐	Jaw Difficulty: Clicking and/or Pain	☐
Lip or Cheek Biting	☐	Sensitivity to Heat	☐	Tooth Pain	☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious Illnesses or operations?	☐	☐
3. Are you currently taking any medication? Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are you:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

AIDS	☐	Emphysema	☐	Pacemaker	☐
Anemia	☐	Epilepsy	☐	Psychiatric Care	☐
Arthritis, Rheumatism	☐	Fainting or Dizziness	☐	Radiation Treatment	☐
Artificial Heart Valves	☐	Glaucoma	☐	Respiratory Disease	☐
Artificial Joints	☐	Headaches	☐	Rheumatic Fever	☐
Asthma	☐	Heart Murmur	☐	Scarlet Fever	☐
Back Problems	☐	Heart Problems	☐	Shortness of Breath	☐
Bleeding abnormally with extractions or surgery	☐	Hepatitis-Type	☐	Sinus Trouble	☐
Blood Disease	☐	Herpes	☐	Skin Rash	☐
Cancer	☐	High Blood Pressure	☐	Stroke	☐
Chemical Dependency	☐	HIV Positive	☐	Swelling of Feet/Ankles	☐
Chemotherapy	☐	Jaundice	☐	Swollen Neck Glands	☐
Chronic Fatigue Syndrome	☐	Jaw Pain	☐	Thyroid Problems	☐
Circulatory Problems	☐	Kidney Disease	☐	Tonsillitis	☐
Congenital Heart Lesions	☐	Latex Sensitivity	☐	Tuberculosis	☐
Cortisone Treatments	☐	Liver Disease	☐	Tumor or growth on head/neck	☐
Cough - persistent or bloody	☐	Low Blood Pressure	☐	Ulcer	☐
Diabetes	☐	Mitral Valve Prolapse	☐	Venereal Disease	☐
		Nervous Problems	☐		

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits, I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

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OUR FINANCIAL POLICY

Payment for treatment is expected at the time service is provided. Cash, personal checks and credit cards are accepted. If an extended payment plan is desired, please ask us about CARE CREDIT. For charges of $500 or greater, a 5% courtesy will be extended for full cash (or check) payment at the time of service.

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most Insurance companies. We will estimate your deductible and the portion not covered by your insurance as closely as possible, but until we actually receive payment from the insurance company, it is just an estimate, Due to the extreme delay in receiving payment from the Insurance company, you will be asked to pay your deductible plus your estimated charges the day the services are rendered. We will assist you in dealing with the insurance company, but ultimately, the responsibility lies with you. If, after 45 days, the insurance company has not paid, the balance will be due in full.

If you have any questions, feel free to ask them at any time. We wish to assist you in any way we can.

Sincerely,

Bruce Miller, D.D.S.

_____ _____ _____

Print Name Signature & Date

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Dr. Bruce Miller, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY,
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We ore also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change In our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Parsons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment 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)

_____
_____
_____

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