

# Miller and Associates

## FAMILY DENTISTRY

Toll-Free: 855-3MY SMILE  
www.denturesinaday.com

☐ 2803 Neuse Blvd  
New Bern , NC 28562  
Ph: 252-672-0066  
Fax: 252-672-0055

☐ 461 Western Blvd  
Ste 104  
Jacksonville , NC 28546  
Ph: 910-346-2202  
Fax: 910-346-2216

☐ 1107 New Pointe Blvd  
Ste 13 & 14  
Leland , NC 28451  
Ph: 910-371-9444  
Fax: 910-371-9474

☐ 808A N Berkeley Blvd  
Goldsboro, NC 27534  
Ph: 919-778-7311  
Fax: 919-778-7310

☐ 8 New Leicester Hwy  
Asheville, NC 28806  
Ph: 828-225-3280  
Fax: 828-225-3289

### PATIENT INFORMATION

Name \_\_\_\_\_ Birthday \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle Nickname Sex: M F Driver's License # \_\_\_\_\_

#### PHYSICAL

ADDRESS \_\_\_\_\_  
Street City State Zip code

#### MAILING

ADDRESS \_\_\_\_\_  
Street City State Zip code

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

e-mail address \_\_\_\_\_ Would you like to be contacted by e-mail? Yes ( ) No ( )

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Last First Middle Nickname

\* How did you find out about our office? \_\_\_\_\_

#### RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Birthday \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle Nickname Driver's License # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Home Phone \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

#### DENTAL INSURANCE INFORMATION

Policy Holder's Name \_\_\_\_\_ Birthday \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle

Ins. Company \_\_\_\_\_ Address: \_\_\_\_\_  
Street City State Zip code

Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Street City State Zip code

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_

**DO YOU HAVE DUAL COVERAGE?** ( ) Yes ( ) No: if Yes, please complete the following:

Policy Holder's Name \_\_\_\_\_ Birthday \_\_\_\_\_ SSN \_\_\_\_\_  
Last First Middle

Ins. Company \_\_\_\_\_ Address \_\_\_\_\_  
Street City State Zip code

Employer: \_\_\_\_\_ Address \_\_\_\_\_  
Street City State Zip code

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_

#### EMERGENCY NOTIFICATION INFORMATION

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Relationship with the patient \_\_\_\_\_

**I WILL INFORM YOUR OFFICE OF ANY CHANGES IN MY INSURANCE COVERAGE**

\_\_\_\_\_  
Patient's Signature / Responsible Party

\_\_\_\_\_  
Date