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

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

❑ 5380 HWY 70 W, Ste. D
Morehead City, NC 28557
Ph: 252-515-7779
Fax: 252-515-1738

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 liked 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**

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CONSENT FOR INITIAL DENTAL TREATMENT

I request and authorize Dr. _____, and/or associates, hygienists or assistants of his/her choice to perform the following treatments/procedure(s) clinically necessary for diagnosis and for treatment planning for my oral health. I further request and authorize a complete dental examination that may include periodontal probing, dental X-rays, intraoral photographs, soft tissue and oral cancer screening and possible diagnostic study models. In addition to these procedures I authorize and request a dental cleaning or initial periodontal therapy and fluoride treatment. The use of anesthetics may be considered necessary and/or advisable by the doctor responsible for my care.

It has been explained to me, and I have had sufficient opportunity to discuss my initial dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment at all.

The usual and most frequent risks or complications occurring from the initial planned treatment and procedures, has also been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during or following treatment, swelling, infection, bleeding, or if local anesthesia is used, the development of a transient numbness or tingling in the lip, chin, cheek, tongue, teeth or gums that me be temporary or permanent.

I understand that during the course of my dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those initially planned. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made concerning the results of the treatment, I will receive. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed for me.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

I confirm that I have read this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were crossed out before I signed below.

Patient Signature: _____
Print Patient Name: _____Date: _____Time:_____
If other than patient, indicate relationship: _____
Witness Signature: _____
Print Witness Name: _____Date: _____Time:_____

Consent Certification
I certify that I have explained the nature, purpose, benefits, the usual and most frequently occurring risks and hazards of, and alternatives to the initial treatment prescribed for the patient. I have offered to answer any questions and have fully answered such questions. I believe the patient/parent/guardian understands what I have explained and has consented to the proposed treatment and procedures.

Signature of Dentist: _____
Print Dentist Name: _____Date: _____Time:_____

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MEDICAL HISTORY

Patient's Name: _____ Birthday: _____ SSN: _____ Today's Date: _____
What is your general state of health? Excellent ____ Good ____ Fair ____ Poor ____

PHYSICIAN'S INFORMATION

PHARMACY: _____

Physician's Name: _____
Physician's Address: _____ **Office Phone #**: _____
Have you been under a physician's care during the last two years? _____
Have you been treated in a hospital in the past three years? _____
Have you had major surgery? _____ What/When? _____
Do you or have you been told to **PRE-MEDICATE** before appointments? _____
IF FEMALE: Are you pregnant? _____ Due Date _____ Nursing? _____ On birth control? _____

Do you have or have you had any of the following? PLEASE MARK YES OR NO (ON ALL)

Yes	No	AIDS/HIV+	Yes	No	Implants
Yes	No	Arthritis	Yes	No	Irregular Heart Beat
Yes	No	Artificial Heart Valves	Yes	No	Kidney Disease
Yes	No	Artificial Joints	Yes	No	Liver Disease
Yes	No	Asthma	Yes	No	Mental illness
Yes	No	Bruise/Bleed Easily	Yes	No	Mitral Valve Prolapsed
Yes	No	Cancer	Yes	No	Nervousness/Anxious
Yes	No	Chemotherapy	Yes	No	Organ Transplant
Yes	No	Chest Pain/Angina	Yes	No	Pacemaker
Yes	No	Congenital Heart Lesions	Yes	No	Osteoporosis
Yes	No	Diabetes	Yes	No	Pneumonia
Yes	No	Dry Mouth	Yes	No	Radiation Therapy
Yes	No	COPD/ Bronchitis	Yes	No	Rheumatic Fever
Yes	No	Epilepsy/Seizures	Yes	No	Sickle Cell Anemia
Yes	No	Fainting/Dizziness	Yes	No	Sinus Problems
Yes	No	Fibromyalgia	Yes	No	Stroke
Yes	No	Heart Problem/Murmur	Yes	No	Thyroid Disease
Yes	No	Heart Surgery	Yes	No	Tobacco Use
Yes	No	Hepatitis A, B, C	Yes	No	Tuberculosis/ PPD+
Yes	No	High Blood Pressure	Yes	No	Cold Sores

MEDICATIONS

Please list **ALL** medications you are taking, including over the counter drugs and herbs.

Are you in a pain management program? Yes No If so, what medication(s) are you taking, including any ADD, ADHD, or sleeping aids _____

Have you had a mastectomy? Yes No

Do you have any drug allergies? PLEASE MARK YES OR NO (ON ALL)

Yes	No	Antibiotics (Erythromycin/Tetracycline/Penicillin/Flagyl)	Yes	No	Dental Anesthetics
Yes	No	Aspirin, Ibuprofen, Acetaminophen	Yes	No	Latex
Yes	No	Codeine	Yes	No	Sulfa

Any other allergies not listed: _____

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Financial Policy

Part of our mission at the offices of Miller and Associates is to provide you with cost effective, state-of-the-art dental care. It is our goal to assist you in obtaining and maintaining the highest level of personal dental health available today.

We want you to have the smile you desire and deserve!

Private Insurance and Cash Pay Patients

We provide the following payment options to our patients.

1. Cash
2. Visa, MasterCard, Discover and Checks.
3. Monthly payment arrangements through a third party lender.

Dental insurance can help aid patients with the cost of healthcare, however, it was never meant to provide 100% coverage for all services that you may want or need. Most dental insurance policies *pay only a percentage* of the total cost of basic care. Your policy is a contract between you, your employer, and your insurance company. We are not notified when changes are made in your policy, coverage, or filing addresses. Therefore, we need your help in providing us with complete, current and accurate insurance information in order to make estimates about your possible benefits.

We will gladly discuss your insurance coverage with you and we will *estimate*, to the best of our ability, what benefits you might expect from the policy your employer has provided for you**. *For any treatment plan of $300.00 or more, we will submit a pretreatment estimate to your insurance company.* The patient's part of the fee will be due at the time of treatment unless otherwise arranged.**

Ultimately, it is the patient or the patient's legal guardian, who is responsible for paying, in-full, all fees incurred through our office, regardless of any other party/agency that might be involved in your payment arrangement. We expect patients to make payments as arranged in a timely manner.

In case of a minor child or dependant patient, the parent or guardian presenting the child to our office will be considered to be the person responsible for the account. Our office cannot enter into negotiating benefits that might be due from an absent parent or legal guardian.

Insurance Patients

We require a copy of a current insurance card and photo ID for all patients. **Please bring the current card with you to each appointment**. We will require a picture identification to verify the ownership of the insurance card. If you are designated for a co-payment, it will be due at the time of check-in for each appointment.

I have read the financial policy of Miller and Associates and I understand and accept my responsibilities as a patient in this office.

SIGNATURE _____ DATE _____

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Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Miller and Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other_____
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse	❑ Family billing information ❑ Financial ❑ Medical as follows:_____
❑ Parent (provide name)_____	❑ Family Billing Information ❑ Financial ❑ Medical as follows:_____
❑ Other (provide name) _____ _____	❑ Financial ❑ Medical as follows _____
❑ Support Group (provide name)_____	❑ Demographic Information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to _____Miller and Associates Family Dentistry_____. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

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Patient Notice

Welcome to Miller and Associates.

We are delighted to have this opportunity to provide effective and efficient dental treatment to the members of our community in a compassionate and professional manner. We hope you will feel comfortable and confident in returning for service and continue to refer others to our practice for our unprecedented treatment. We look forward to helping you and your family. May it be a wonderful experience.

We look forward to working with you.

Please be aware of the following:

Because of the limited number of appointments available we ask that you come to your appointments on time. If you should need to cancel an appointment, we ask that you give us 24HRS notice. Any notice less than 24HRS is considered a broken appointment. After three missed or broken appointments you will be dismissed from the practice.

A $30.00 fee per broken appointment may be charged.

Thank you for your attention to this matter.

Patient signature: _____

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Release of Liability

The waiver, release and other representations and covenants set forth herein are given in consideration for Miller and Associates for performing dental procedures.

Acceptance of Risk; Release; Indemnification.

1. I _____, am fully aware and acknowledge the extremely contagious nature of COVID-19 and voluntarily assume the risk that I and/or my child may be exposed to or infected by COVID-19 by entering Miller & Associates Family Dentistry and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

2. I will follow all of the protocols provided in the adjoining letter.

3. I certify that neither I, nor anyone in my household, nor any child that is accompanying me,

    a. Has tested positive or has been presumed positive for COVID-19 at any time during the past 14 days;
    b. Has been advised by a healthcare professional to self-quarantine at any time during the past 14 days;
    c. Has been in close physical contact with someone who has tested positive for COVID-19 or who has been presumed positive for COVID-19, during the past 14 days; or
    d. Is subject to a quarantine order of a recommendation of a healthcare profession that in either case, would make it inadvisable to have dental work performed at Miller and Associates Family Dentistry; or
    e. Has, within the past 24 hours, exhibited any of the following symptoms: fever of 100.4 or greater, cough, shortness of breath.

4. On behalf of myself and/or my child and our heirs, successors and assigns, I knowingly and freely, assume all such risks, both known and unknown, relating to my and/or my child's entry to Miller & Associates Family Dentistry and I hereby forever release, waive, relinquish, and discharge Miller & Associates Family Dentistry, along with their officers, agents, owners, employees, or other representatives, and their successor and assigns (collectively, the "Miller Representatives") from any and all claims, demands, liabilities, rights, damages, whether known or unknown, foreseen or unforeseen, (collectively, "Damages") as a result of me and/or my child being treated at Miller & Associates Family Dentistry, including but not limited to those related to the above described personal injuries, death, disease or property losses, or any other loss, and including but not limited to claims based on the alleged negligence of any Miller & Associates Representatives, or any of Miller & Associates Representatives, and agree to indemnify and hold them harmless from any and all Damages resulting from my being treated at Miller & Associates Family Dentistry.

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DO NOT SIGN IF YOU HAVE NOT CAREFULLY READ THIS ENTIRE RELEASE OF LIABILITY, BY SIGNING BELOW YOU AGREE TO EVERYTHING IN THIS RELEASE OF LIABILITY.

READ CAREFULLY—BY SIGNING THIS DOCUMENT YOU MAY GIVE UP IMPORTANT LEGAL RIGHTS.

Print Name _____ SIGNATURE _____

DATE _____

Parent/Legal Guardian (If patient is under 18 years old or subject to guardianship)

Print Name _____ SIGNATURE _____

DATE _____

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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Miller and Associates, Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

Provided By MedSafe

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CONSENT TO PATIENT AUDIO RECORDING

Healthcare providers today spend a significant amount of time documenting patient care. To support our mission of providing high-quality care, we are now employing technology which uses artificial intelligence to record audio (not video) of patient visits. This technology significantly reduces the amount of time your provider spends on documentation and allows more time for him/her to provide direct patient care to you. The technology uses a third-party service provider to process recorded audio. All documentation is reviewed, edited and approved by your provider to ensure the accuracy and completeness of your medical record.

We ask you to sign this form to indicate your consent to have your visit(s) recorded and processed in this manner for the purpose of documenting your care.

BENEFITS

This tool is intended to assist your dental provider with drafting documentation and notes, allowing the dental care provider to be more focused on you and your treatment. This tool also helps ensure all details of your appointment are captured, resulting in an accurate, comprehensive record of your appointment. The tool will run silently along with your appointment, and you should notice few if any changes to your experience.
The tool is NOT used for making independent treatment decisions about your care or directly interacting with you. Your dentist will review, edit as necessary, and approve all AI-generated content before it is placed in your dental record.

RISK

While this technology often works very well, it can also make errors. This is why your dental provider will review and approve all content before it is placed in your dental record.
This practice is required by federal law (HIPAA) to safeguard your health information. We will use the AI scribe only to perform the work described above, and your data will not be used to train AI models. Your recording and transcripts stay inside our practice's secure account and are used only by your care team.
No technology is entirely free of security risk; encryption, contracts, and strict access limits reduce that risk. AI is a support tool and does not replace your clinician’s judgment.

ALTERNATIVES

You may decline to consent to the use of this AI tool. If you do not consent, your dental care provider will document your appointment using traditional methods. You may also withdraw your consent at any time.

CONSENT

I understand that patient care services will be recorded only by the provider treating me unless I have expressly consented and signed a release of information for others to record my visit, or unless another exception to confidentiality applies. Such recordings may include protected health information covered under HIPAA.

I further understand that if I request that a family member, friend or other third party ("Approved Third Party") be present in the room where my visit is being recorded, it also will be necessary to obtain the consent of the Approved Third Party.

I understand that recording my visit is not a requirement for me to receive treatment from my provider.

My agreement and participation in recording my visits are knowing and voluntary. Further, I understand that I may withdraw my consent for recording visits or ask questions about my recordings at any time. I acknowledge that I have been provided with a HIPAA Notice of Privacy Practices by practice.

I understand that my consent is voluntary, and my care will not be conditioned on providing consent.

I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke my consent to the recording of future visits at any time.

☐ Yes ☐ No Date: _____

_____

Print Patient Name

_____

Signature of patient or legal representative

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PATIENT SCREENING FORM

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	❑ Yes ❑ No	❑ Yes ❑ No
Are you/they having shortness of breath or other difficulties breathing?	❑ Yes ❑ No	❑ Yes ❑ No
Do you/they have a cough?	❑ Yes ❑ No	❑ Yes ❑ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	❑ Yes ❑ No	❑ Yes ❑ No
Have you/they experienced recent loss of taste or smell?	❑ Yes ❑ No	❑ Yes ❑ No
Are you/they in contact with any COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	❑ Yes ❑ No	❑ Yes ❑ No
Is your/their age over 60?	❑ Yes ❑ No	❑ Yes ❑ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	❑ Yes ❑ No	❑ Yes ❑ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	❑ Yes ❑ No	❑ Yes ❑ No

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Authorization to Release Health Information to another Health Care Provider

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____

Name & address of Covered Entity authorized to release information:

_____

_____

_____

Forward information to:

_____

_____

_____

The information below will be used for patient care. (Description of PHI needed)

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____ _____.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)