GARY L. MILLER, DDS
DUSTIN J. JOUBERT, DDS

Thank You For Choosing Our Office!

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (PLEASE PRINT) Home Phone (____) _____

Cell Phone (____) _____

Patient _____
LAST NAME FIRST NAME INITIAL PREFERRED NAME

Street Address _____ City _____ State ____ Zip ____

Sex: ☐ M ☐ F Age _____ Date of Birth _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation _____ Business Phone (____) _____

Spouse/Parent Name _____ Spouse/Parent Birth date _____

Spouse/Parent Employed by _____ Occupation _____ Business Phone (____) _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent Social Security # _____

Name of Dental Insurance Company _____ Group Number _____

In Case of Emergency, who should be notified? _____ Daytime # _____ Evening # _____

Friend Relative (Circle One) Relationship _____

A contact person living outside the home: _____ Daytime # _____ Evening # _____

Friend Relative (Circle One) Relationship _____

Whom may we thank for referring you? _____

Have any members of your immediate family ever seen Dr. Miller? ☐ Yes ☐ No Name _____

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

☐ Heart Problems
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory Problems
☐ Nervous Problems
☐ Radiation Treatment
☐ Artificial Heart Valves or Joints
☐ Recent Weight Loss
☐ Back Problems
☐ Diabetes
☐ Respiratory Disease
☐ Epilepsy
☐ Headaches
☐ Hepatitis, Jaundice or Liver Disease
☐ Cancer
☐ Psychiatric Care
☐ Chronic Diarrhea
☐ Allergies to Anesthetics
☐ Allergies to Medicine or Drugs
☐ General Allergies
☐ Blood Disease
☐ Arthritis
☐ Glaucoma
☐ Special Diet
☐ Swollen Neck Glands
☐ Rheumatic Fever
☐ Sinus Problems
☐ HIV/AIDS or other Immunosuppressive Disorders
☐ Stroke
☐ Ulcer
☐ Venereal Disease
☐ Chemical Dependency
☐ Hemophilia
☐ Tobacco Use

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what ? _____

_____

Have you ever had a bad experience during or after a dental procedure? _____ If so, explain _____

Are you taking any medication at this time? _____ If so, what? _____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

Do you have any dental concerns or questions? ____ Briefly explain: _____

_____

Method of Payment (check appropriate box): ☐ Cash ☐ Check ☐ Visa ☐ Master Card ☐ Care Credit

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. A MONTHLY CHARGE OF 1½% PER MONTH (18% PER YEAR) WILL BE ADDED ON ALL ACCOUNTS NOT PAID WITHIN 30 DAYS. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

OVER ☞

Miller & Joubert Dental
Gary L. Miller, DDS & Dustin Joubert, DDS
806 N. Main St.
Jennings, LA 70546
Phone (337) 824-2422
www.joubertmillerdental.com

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, medical physicians and dental specialist, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. ***Spouses are not automatically included; their names must be explicitly stated below***. You may opt out by checking the "Do not release information" box below.

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or speak with the office of Miller & Joubert Dental, on my behalf regarding appointments, financial, insurance and dental treatment.

Name(s) _____ Relationship _____

Phone No. _____

Name(s) _____ Relationship _____

Phone No. _____

__ **DO NOT** RELEASE INFORMATION TO ANYONE

I understand that my consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my dental healthcare provider should I wish to change one or more contacts listed above.

Patient's name: _____ DOB: _____
Print

Patient's Signature: _____ Date: _____
Patient or Authorized Representative

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for **ALL CHARGES** whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

Gary L. Miller, DDS, Inc.
Dustin J. Joubert, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gary L. Miller, DDS, Dustin J. Joubert, DDS

Telephone: (337) 824-2422 **Fax:** (337) 824-0047

Address: 806 N. Main Street, Jennings, LA 70546

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

GARY L. MILLER, DDS
DUSTIN J. JOUBERT, DDS
Office of Family Dentistry
806 N. Main Street
Jennings, LA 70546
(337) 824-2422

Cancellation and No-Show Policy

We understand that unplanned issues can come up and you may need to cancel your appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance. Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of ***dismissing patients for chronic no-show appointments***. All new patients who don't show for their **first** initial visit will not be rescheduled. Once you are an established patient with repeated no-shows you will be dismissed from our office and all previously scheduled upcoming appointments will be cancelled.

We want to stress that as a **courtesy** our office sends out a text message to your cell phone before your scheduled appointment. You are ultimately responsible for any and all scheduled appointments. It is the patient's responsibility to contact our office in advance for cancelling and rescheduling appointments.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Sincerely,

Gary L Miller, DDS

Dustin Joubert, DDS

I understand the terms of this form. I realize that I am responsible for my scheduled dental appointments and that a text message or phone call as a reminder is simply a courtesy provided by Miller & Joubert Dental.

Patient's signature: _____

Parent/Guardian's signature: _____

Date: _____