Miller's Family Dentistry

1409 N. Tracy Blvd. • Tracy, CA 95376 (209)835-5116

Patient Information

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Title: ________ (Mr/Ms/Mrs/etc) **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: ________ **Prev. Visit:** ________ **Email Address:** ____________

Phone: ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) **Best time to call:** ____________

Address: ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

Whom may we thank for referring you to our practice?

☐ Google ☐ Website ☐ Insurance Plan ☐ Friend/Family ☐ Staff ☐ Walk-In/Street Sign
☐ Other (name below):

Name of person, office, or other source referring you to our practice:

____

Are you covered by a Dental Insurance? ○ Yes ○ No

Responsible Party Information

The following is for: ○ the patient's spouse ○ the person responsible for payment ○ both ○ neither-not applicable

Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Address: ____________ (Address 1) ____________ (Address 2)

____________ (City) ____ (State) _____-____ (Zip Code)

Responsible Party SS# ____________

Primary Insurance Information

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____

Employer Name: ________________

Primary Insurance / Responsible Party Social Security# or Member ID# ________________

Primary Insured DOB ________________

Are you covered by a Secondary Insurance? ◯ Yes ◯ No

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: ______________________ ______________________ ____
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____

Employer Name: ________________

Secondary Insurance / Responsible Party Social Security# or Member ID# ________________

Secondary Insured DOB ________________

Millers Family Dentistry
Consent for Services

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa and MasterCard, American Express or Discover Card

-We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care.

- Convenient Monthly Payment Plans* from CareCredit
+ Allow you to pay over time
+ No Annual Fees or Pre-payment Penalties

Please Note:

Ronald G. Miller DDS, Inc. requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For treatment requiring multiple appointments, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.**

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice.

Ronald G. Miller, DDS, Inc. charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

***Subject to credit approval**
****However, if we do not receive payment from your dental insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collecting benefits directly from your insurance carrier.**

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature ______________________________ **Date** ____________

Response Date: ____/____/________