

# WELCOME TO DR. MILLER AND ASSOCIATES

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH  
**SO PLEASE FILL THIS FORM OUT COMPLETELY**

NAME OF PATIENT \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SEX: M F AGE: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
MARITAL STATUS: S M D W  
HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
OCCUPATION \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
OFFICE PHONE \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_  
STREET \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_

## WHOM MAY WE THANK FOR REFERRING YOU TO US?

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EMERGENCY CONTACT \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

NAME OF COMPANY \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ NAME OF PERSON \_\_\_\_\_  
INSURED \_\_\_\_\_ D.O.B \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

NAME OF COMPANY \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP \_\_\_\_\_



MEDICAL HISTORY

Have you had any serious illnesses? If yes, please explain:

Circle if you have (or had) a problem with any of the following:

Diabetes	Lungs	Asthma	Rheumatic Fever	Heart	Liver
Stroke	Kidneys	Thyroid	Stomach Ulcer	Phlebitis	Arthritis
Cancer	T.B.	Murmur	Hypertension	Bladder	AIDS/HIV
Skin	Anemia	Gout	Psychological	Epilepsy	Circulation

For women: Are you pregnant or breast feeding? Yes No

ALLERGIES

Are you allergic or sensitive to any of the following (Please circle)? Please explain the reaction you get to the offending substance.

( ) Please check this box if you have NO KNOWN DRUG ALLERGIES

Penicillin	Morphine	Tape	Sulfa	Novocaine	Latex
Aspirin	Codeine	Iodine	Neosporin	Betadine	"-mycins"

Others (please list): \_\_\_\_\_

HOSPITALIZATIONS—Have you ever been hospitalized for any reason? If so, please list when, where and for what reason. ( ) Please check this box if you have never been hospitalized

TRAUMATIC HISTORY—Have you ever had any SERIOUS injuries, accidents, or broken bones? If so, please list when, your treatment, and outcome.

SURGERIES—Please list any surgeries that you have had. Please include when, where, and what surgical procedures. ( ) Please check this box if you have never had surgery

Have you ever had a reaction or complication from anesthesia or surgery? If so please explain.  
( ) Please check this box if you have NOT had complications from anesthesia or surgery

FAMILY HISTORY—Please circle if any of your family members have (or had) any of the following:

Diabetes      Cancer      Heart Disease      Hypertension      Foot Problems

SOCIAL HISTORY

Your occupation: \_\_\_\_\_

Do you smoke?    Yes    No                      Number of packs per day:\_\_\_\_\_    Number of years:\_\_\_\_\_

Previously Smoked?    Yes    No                      Number of packs per day:\_\_\_\_\_    Number of years:\_\_\_\_\_

Do you drink alcohol?    Yes    No

How would you describe your drinking? Circle those that apply:

Social      Light      Moderate      Heavy      Binge      Rarely      Never

Do you use recreational/illicit drugs?    Yes    No                      Type:\_\_\_\_\_

Are you involved in a sport or exercise program?    Yes    No    Please explain below:

We are dedicated to providing the best possible care and service to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office manager and/or front office staff.

### Health Insurance

We are contracted with most insurance plans to accept assignment of benefits. Our office will file your visit with the insurance company and will only collect your co-pay, deductible, and/or coinsurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit.

If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from this office.

### Referrals

It is your responsibility to obtain a valid referral from your primary care physician when required by your insurance company.

### Disability, Insurance Forms, Medical Records, and Copies of X-rays

There is a \$10.00 per form charge to fill out disability and insurance forms. Please mail or leave them at the front desk along with your payment. Forms will not be completed until payment is received. Please allow at least 3-5 working days for processing. We will call you once we have completed your request. There is a \$20.00 fee for copying x-rays and \$5.00 fee for medical records.

### Medication Refills

Refills for medication prescribed by your doctor should be obtained by calling your pharmacy to request the refill. Please do not call the office, as this will only result in additional phone calls for you. Refills are not approved after normal business hours, weekends, or holidays, so please call in your refill request in time for the pharmacy to contact our office.

### Cancellation Policy

Our office will make every attempt to confirm your scheduled appointment, but it is ultimately your responsibility to cancel or reschedule when necessary. Our office reserves the right to charge a \$25.00 fee for failure to inform our office of appointment cancellation.

I have read and understand the office policies, and I agree to be bound by it's terms. I also understand and agree that such terms may be amended from time to time by the practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name