

Miracle Dental Associates, LLC Registration

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL				
Name _____				
_____	_____	_____	_____	(Preferred)
Birthdate _____	SS# _____	Gender: [ ] M [ ] F	Married: [ ] Y [ ] N	
Work Phone _____	Wireless Phone _____	Wireless Carrier _____		
Email _____				
Preferred contact method	[ ] HmPhone	[ ] WkPhone	[ ] WirelessPh	[ ] Email
Preferred contact method for confirmations	[ ] HmPhone	[ ] WkPhone	[ ] WirelessPh	[ ] Email
Preferred contact method for recall	[ ] HmPhone	[ ] WkPhone	[ ] WirelessPh	[ ] Email
Student status if dependent over 19 (for ins)	[ ] Nonstudent	[ ] Fulltime	[ ] Parttime	
How did you hear about us? _____				
(If someone referred you here, please write down their name so we can thank them.) _____				
ADDRESS AND HOME PHONE				
Check box if same for entire family [ ]				
Address _____				
Address 2 _____				
City _____	State _____	Zip _____		
Home Phone _____				
INSURANCE POLICY 1				
Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child				
Subscriber Name _____		Subscriber ID # _____		
Insurance Company _____		Phone _____		
Employer _____	Group Name _____	Group # _____		
Please present insurance card to receptionist.				
INSURANCE POLICY 2				
Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child				
Subscriber Name _____		Subscriber ID # _____		
Insurance Company _____		Phone _____		
Employer _____	Group Name _____	Group # _____		

Comments:

Patient / Guardian Signature:

Date: