



# Miracle Dental Associates, LLC REGISTRATION FORM

(Please Print All Information)

I prefer to be called:

Today's date:				E-mail:					
PATIENT INFORMATION									
Patient's last name:		First:		MI:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Social Security no.:		Home phone no.:		( )	
P.O. box:		City:		State:		ZIP Code:			
Occupation:		Employer/Address:				Employer phone no.:		( )	
To whom may we thank for referring you?				Previous/Present Dentist:					
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages	Phone No.:		( )		
Physician:		Address:				Phone No.:			

INSURANCE INFORMATION									
(Please give your insurance card to the receptionist.)									
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.:		( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Occupation:	Employer:	Employer address:				Employer phone no.:		( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:	Policy no.:	Co-payment:	\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other				
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:	Policy no.:		
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other				

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.:	Work phone no.:
			( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Miracle Dental Associates, LLC or insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date