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_____
Last First MI (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: