SMILES BY MIA

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is: □ Responsible Party □ Policy Holder □ Dependent

Address: _____ Apt# _____

City. State. Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail _____ □ I would NOT like to receive text correspondences

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ □ I would like to receive email correspondences

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○ Full Time ○ Part Time

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Company: _____ Employer Name: _____

Employer ID: _____ Group #: _____

Policy Holder Social Security #: _____ Policy Holder Birth Date: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer Name: _____ Insurance Company: _____

Employer ID: _____ Group #: _____

Policy Holder Social Security #: _____ Policy Holder Birth Date: _____

Emergency Contact

First Name: _____ Last Name: _____

Address: _____ Apt= _____

City. State. Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our office? _____

When was your last dental visit? _____

Do you have any dental concerns. if yes please specify? _____

_____