

PATIENT REGISTRATION

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

E-mail: _____ Who referred you to Miller Dental Arts? _____

Patient Information

Address: _____ Address 2: _____

City _____ State: _____ Zip: _____ Driver's Licence #: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile _____

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

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Carrier ID: _____ Pref. Pharmacy: _____

Employer ID: _____ Pharmacy Phone: _____

What is the primary reason for your visit?

Responsible Party (if other than patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Mobile _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

PRINT NAME OF PATIENT, PARENT, GUARDIAN, or PERSONAL REPRESENTATIVE _____ RELATIONSHIP _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, or PERSONAL REPRESENTATIVE _____ DATE _____