MILLER
FAMILY DENTAL

PATIENT INFORMATION

First _____ M ____ Last _____ Preferred Name _____
DOB _____ Gender: ___ Male ___ Female ___ Prefer not to say
SS# _____
Address _____ City_____ State _____ Zip _____
Email Address _____
Home Phone _____ Cell Phone _____
Spouse or Parent's Name _____ Phone _____

Emergency Contact _____ Relationship _____
Emergency Contact Phone _____

How did you hear about our office? (Circle all that apply)
TV | Google | Website | Drive By | Friend | Patient Other _____

INSURANCE INFORMATION

Insurance Company _____ Customer Service Phone _____
Group/Policy _____ ID _____

Fill the section below if you are a dependent on the policy:
Policy Holder _____ Policy Holder DOB _____
Policy Holder SS# _____

CONTACT AUTHORIZATION

Consent to email or text usage for appointment reminders include: email, calls, and/or text messaging to remind you of an appointment, obtain feedback on your experience with our healthcare team, and to provide general health reminders or information. Standard messaging rates may apply as provided in your wireless plan.

[ ] **Accept** I authorize Miller Family Dental to contact me at the phone numbers, emails, and any additional contact information provided to the office.

[ ] **Decline** I do not wish to receive text messages and/or emails from the practice. I request all communications be done through phone calls only.

Please keep in mind if your cell phone number is linked to other accounts, you may get messages about their appointments as well.

_____ _____
Signature Date

Miller Family Dental
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