Mueller & ASSOCIATES

Family and Cosmetic Dentistry

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____

Middle Initial: ____ **Preferred Name:** _____ **Responsible Party (for dependents):** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____ **Sex:** **M | F** **Birthdate:** _____

Preferred Method of Contact: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Email**

Social Security: _____ **Email:** _____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance

Subscriber Name: _____ **Subscriber DOB:** _____

Insurance Company: _____ **Subscriber/Member ID/Social Security:** _____

Group Name: _____ **Group Number:** _____ **Phone Number:** _____

Secondary Insurance

Subscriber Name: _____ **Subscriber DOB:** _____

Insurance Company: _____ **Subscriber/Member ID/Social Security:** _____

Group Name: _____ **Group Number:** _____ **Phone Number:** _____