

Stacy E. Miller, D.D.S., M.S.
Specialist in Orthodontics for Children & Adults

Patient Information

Date _____	
Patient's Last Name _____	First _____ Nickname _____ MI _____
Street Address _____ City _____ State _____ Zip Code _____	
Home Phone (____) ____ - ____ Birthday ____/____/____ Sex: Male/Female S.S.N. ____ - ____ - ____	
If patient is a minor, give parents or guardian's name _____	
School _____	Grade: _____
Hobbies _____ Sports/Instruments Played _____	
Brothers (names & ages) _____	
Sisters (names & ages) _____	
Whom may we thank for referring you to our office? _____	
General Dentist _____	Location _____
Other family members treated by Dr. Miller _____	

Responsible Party Information

Last Name _____		First _____		MI _____	
Street Address _____		City _____		State _____ Zip Code _____	
Home Ph (____) ____ - ____		Cell Ph (____) ____ - ____		Work Ph (____) ____ - ____ Martial Status _____	
S.S.N. ____ - ____ - ____		Relationship to patient _____		Birthday ____/____/____	
Employer _____		Occupation _____		Email _____	
_____ - _____					
Spouse's Last Name _____		First _____		MI _____	
Street Address _____		City _____		State _____ Zip Code _____	
Home Ph (____) ____ - ____		Cell Ph (____) ____ - ____		Work Ph (____) ____ - ____ Martial Status _____	
S.S.N. ____ - ____ - ____		Relationship to patient _____		Birthday ____/____/____	
Employer _____		Occupation _____			

Dental Insurance Information

Insured Last Name _____		First _____		MI _____	
Insured S.S.N. ____ - ____ - ____		Relationship to patient _____		Birthday ____/____/____	
Insurance Co. _____		Ins. Co. Ph. (____) ____ - ____		Group No. _____	
Insured's Employer _____		Do you have secondary insurance? Y/N			
Office Use Only					
Insured Name _____		SSN ____ - ____ - ____		Birthday ____/____/____	
Insurance Co. _____		Phone No. (____) ____ - ____		Group No. _____	
Effective Date ____/____/____		LTM \$ ____ or ____ % Deduct. \$ ____ per ____		Age Limit _____	
Mail claims to _____					
Initial ____		Qtr. ____		Mo. ____ Auto. ____	

Emergency Information

Name of nearest relative not living with you _____	
Complete Address _____	
Phone (____) ____ - ____	Relationship to patient _____