SMILES BY MIA
COSMETIC & GENERAL DENTISTRY

(703) 323-1300
8989 Fern Park Dr.
Burke, VA 22015

# NEW PATIENT REGISTRATION

First Name: ____________________ Last Name: ____________________________ Middle Initial: ______
Patient is: ☐ Responsible Party ☐ Policy Holder ☐ Dependent
Address: ______________________________________________________________
City, State, Zip: __________________________________________________________
Home Phone: _________________ Work Phone: _________________ Cell Phone: ________________
E-Mail _________________________________
Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
Birth date: _______________ Social Security #: __________________ Drivers Lic#: _______________
Employment Status:
☐ Full Time ☐ Part Time ☐ Self Employed ☐ Retired ☐ Unemployed ☐ Student ☐ Minor

## 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: _________________

## Medical 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: ___________________________________
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? ____________________________________
______________________________________________________________________________
______________________________________________________________________________


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