Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

MARKO M. KAMEL, DDS, FAGD, MIDIA • 5565 Blaine Avenue, Suite 290 • Inver Grove Heights, MN 55076 • (651) 552-0404

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ____/_____/_____ SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ____/_____/_____

SSN# _____

Relationship: _____

About Dr. Kamel:

Doctor of Dental Surgery - University of Minnesota
Fellow of The Academy of General Dentistry
Master of The International Implant Association

YOUR PREFERENCES

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at: [ ] Home [ ] Work [ ] Cell
Whom may we thank for referring you? How do you wish to be addressed by our staff?

_____ _____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____

DENTAL INSURANCE:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____ SSN# _____ Employer: _____

Insurance Company _____ Subscriber ID # _____ Group #:_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____ SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

Our Mission Statement: To provide high-quality, effective patient care for head, neck and teeth disorders through a multispecialty, interdisciplinary approach designed to reduce pain and improve function for all our patients.

CONFIDENTIAL