WELCOME

Patient's Name ___________________________________

Date of Birth _____________________________________

How you wish to addressed _________________________

Single__ Married___ Divorced___ Widowed___ Minor__

Address ____

City ____________________ State ______ Zip _________

Employer ____

Address____

City____________________ State______ Zip__________

Position ____________________ How Long?__________

Telephone Home __________________________________

Business________________ Cell ____________________

Email ____

Patient SSN ____________-_________-_______________

Driver's License No. ______________________ State ___

Spouse/Parent Name______________________________

Employer ____

Address____

City____________________ State______ Zip__________

Position ____________________ How Long?__________

Spouse/Parent SSN ___________-________-___________

Emergency Contact ________________________________

Home Telephone # ____________________________

Cell # ____________________________________

Purpose of first Visit______________________________

Other Family Members in Practice___________________

Whom may we thank for this referral_________________?

Who is responsible for this account?

____

Method of Payment Cash____ CC/Debit____ Check_____

Dental Insurance Coverage

Subscriber Name__________________________________

Subscriber DOB___________________________________

Employer of Insured_______________________________

Name of Ins Co.__________________________________

Address____

City____________________ State______ Zip__________

Dental Insurance Coverage

Relationship of Patient to Subscriber__________________

Telephone# of Ins. Co. ____________________________

Policy #____

Group #____

ID # or SSN #_____________________________________

I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my Records shall be in effect until I revoke it in writing.

I attest to the accuracy of the information I have provided on this page.

____

Patient or Guardian Signature

Date____

Patient Registration

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W. Carl McMillan, DMD