



MILLS & SHANNON DENTISTRY

COMFORT, CONFIDENCE & EXCELLENCE.

PATIENT INFORMATION

First Name	_____	Last Name	_____	Middle Initial	_____	Preferred Name	_____
Physical Address	_____			City	_____	State	_____
	_____					Zip Code	_____
Mailing Address	_____			City	_____	State	_____
	_____					Zip Code	_____
Home Phone	_____	Work Phone	_____	Ext	_____	Cell Phone	_____
Birth Date	_____	Social Security #	_____	Email Address	_____		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time				
How did you hear about us?	_____				Previous Dentist	_____	
Emergency Contact Name	_____				Phone	_____	

RESPONSIBLE PARTY INFORMATION (IF SOMEONE OTHER THAN THE PATIENT)

First Name	_____	Last Name	_____	Middle Initial	_____		
Physical Address	_____			City	_____	State	_____
	_____					Zip Code	_____
Mailing Address	_____			City	_____	State	_____
	_____					Zip Code	_____
Home Phone	_____	Work Phone	_____	Ext	_____	Cell Phone	_____
Birth Date	_____	Social Security #	_____	Email Address	_____		

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name	_____	Policy Holder's Social Security #	_____
Policy Holder's Date of Birth	_____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insurance Company Name	_____	Employer Name	_____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name	_____	Policy Holder's Social Security #	_____
Policy Holder's Date of Birth	_____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insurance Company Name	_____	Employer Name	_____