

MCMILLIAN DENTAL SOLUTIONS

REGISTRATION FORM

(Please Print)

Today's Date:			ADI #		
PATIENT INFORMATION					
Patient's Name: Last:		First:		Middle:	
				Marital status (circle one)	
				Single / Mar / Div / Wid	
Street Address:			City:	State:	Zip:
Birthdate:	Age:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:	
Home Phone:	Work Phone:	Cell Phone:	Receive text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email:			Full Time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referred by:		RESPONSIBLE PARTY: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian			

PRIMARY INSURANCE (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Responsible Party / Subscriber's Name:		Driver's License#:	
Social Security #:	Birth date: / /	Subscriber #	Group #
PRIMARY INSURANCE & PHONE #:		Employer:	
Emergency Contact Name:		Phone:	

AUTHORIZATION

I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I grant the right to the dentist to release my dental / medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Signature

Date

CANCELLATION POLICY

We reserve time specific to your appointment type. If it becomes necessary to reschedule your appointment, we require 48 hours advance notice. We reserve the right to charge \$55.00 for missed appointments and appointments cancelled with a notice less than 48 hours.

Signature

Date

OFFICE POLICY

WE FILE INSURANCE AS A COURTESY TO YOU. INSURANCE IS NEVER A GUARANTEE OF PAYMENT. ANYTHING NOT COVERED OR PAID BY INSURANCE IS YOUR RESPONSIBILITY. To the best of our ability we will inform you ahead of time of anything you will be required to pay. *WE REQUIRE YOU TO PAY YOUR CO-PAY AT THE BEGINNING OF EACH VISIT.* Situations during treatment may occur to cause additional fees or credits to your account. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature

Date