Mill Creek Dental Care

Timothy E. Skidmore, D.D.S., P.C.

Patient Registration Form

Patient Information (confidential)

First Name _____ Middle Initial ___ Last Name _____ Preferred Name _____
Address _____ City _____ State ____ Zip Code _____
Email _____Home Phone: (_____)_____-_____
Work Phone: (_____)_____-_____ext: ____ Mobile Phone: (_____)_____-_____
How would you like our office to contact you to confirm scheduled appointments? (Please circle)
Phone call via: Home, Work, Mobile, or E-mail
Birth Date: _____/_____/_____ SS# _____-_____-_____ Gender: *Male / Female*
Circle Which Applies: *Minor, Single, Married, Separated, Divorced, Widowed*
If Student, Name of School/College _____ City _____ State _____ Full Time/Part Time
How did you learn about our office? _____
Person to Contact in Case of Emergency _____

Responsible Party

Person Responsible for this Account:
First Name _____ Middle Initial ___ Last Name _____ Preferred Name _____
Relationship to Patient _____
Address _____ City _____ State ____ Zip Code _____
Email _____ Home Phone: (_____)_____-_____
Work Phone: (_____)_____-_____ext: ____ Mobile Phone: (_____)_____-_____
Birth Date: _____/_____/_____ SS# _____-_____-_____ Gender: *Male / Female*
Is this Person Currently a Patient in our Office? *Yes / No*

Dental Insurance Information

Insured First Name _____ Middle Initial ___ Last Name _____
SS# _____-_____-_____ Relationship to Patient _____ Birth Date: _____/_____/_____
Address _____ City _____ State ____ Zip Code _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Address _____ City _____ State ____ Zip Code _____
Insurance Phone# (_____)_____-_____
Name of Employer _____ Union of Local # _____ Work Phone: (____)_____-_____
Employer Address _____ City _____ State ____ Zip Code _____

Do You Have Any Additional Dental Insurance? *Yes/ No* If Yes, Complete the Following

---

Insured First Name _____ Middle Initial ___ Last Name _____
SS# _____-_____-_____ Relationship to Patient _____
Address _____ City _____ State ____ Zip Code _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Address _____ City _____ State ____ Zip Code _____
Name of Employer _____ Union of Local # _____ Work Phone: (____)_____-_____
Employer Address _____ City _____ State ____ Zip Code _____