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Wadsworth, Ohio 44281
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Patient Info

First Name _____ Last name _____ Preferred Name _____

Date of birth _____ SS# _____

Driver's license number _____

Male _____ Female _____ Marital Status _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ E-mail _____

Whom may we thank for referring you? _____

Is another member of your family a patient in our office?

What is your main objective for scheduling this appointment at our office?

Insurance Info

Primary Dental Insurance:

Employer _____ Insured's Name _____

Insured SS# _____ Member ID/Subscriber ID _____

Group # _____

Relation to patient _____ Date of birth _____

Secondary Dental Insurance:

Employer _____ Insured's Name _____

Insured SS# _____ Member ID/Subscriber ID _____

Group # _____

Relation to patient _____ Date of birth _____