

Dunwoody Dental Care

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Sex: M F Date _____
(first) (MI) (last)

Patient's Birthdate _____ Social Security Number _____ - _____ - _____ Height _____ Weight _____

Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Home Address _____
(street) (city) (state) (zip)

Home Telephone _____ Work Telephone _____ Cell Phone _____

Patient's Occupation _____

Patient's Employer _____

Business Address _____
(street) (city) (state) (zip)

E-mail Address _____

Spouse's Name _____
(first) (MI) (last)

Spouse's Birthdate _____ Social Security Number _____ - _____ - _____

Spouse's Occupation/Employer _____ Work Telephone _____

In case of emergency, please contact _____ Telephone _____

How were you referred to this office? (Please be specific) _____

Reason (and Concerns) for today's visit _____

FEES

All fees are due at the time of service

Please indicate your method of payment:

MasterCard. Visa. Discover. Amer. Express

(Account # _____ Exp Date _____)

Check or cash in full at time of visit

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name _____

Employer _____

Insurance Co. _____

Policy No. _____

Group No. _____

Insurance Co. Phone No. _____

Coverage: Family () Individual ()

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I personally guarantee payment of all services rendered, whether I am utilizing insurance benefits or not.

Patient's Signature _____ Today's Date _____