# 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 ______________