THE DENTIST
WINDWARD PARKWAY CENTER

3070 Windward Plaza, Suite R, Alpharetta, GA 30005
678-366-2322 www.thesmileexperience.com

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL PATIENT INFORMATION
(MARK FIELDS THAT DO NOT APPLY TO YOU AS "n/a")

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle Initial:_____

Preferred Name:_____ Birth Date:_____/_____/_____ Social Security #:_____-_____-_____

Address: _____

City/State/Zip: _____ Email Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #:_____

Gender: ( ) Male ( ) Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Long Term Partner

Employer:_____ Occupation:_____

How did you hear about our office? ( ) Internet ( ) Insurance ( ) Location ( ) Advertisement

Friend/Family/Relative (Name): _____ ( ) Other _____

DENTAL INSURANCE

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Birth Date: _____/_____/_____ Policy Holder SS#: _____-_____-_____ Policy Holder ID#_____

Insurance Company: _____ Insurance Company Phone #:_____

Policy Holder Employer:_____ Policy Holder Occupation:_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____ Relationship:_____

Home Phone: _____ Cell Phone:_____

_____ _____
Signature of Patient or Parent Date

_____ _____
Doctor Signature Date