

THE DENTIST

SANDY SPRINGS 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