DENTISTRY AT SUWANEE

Name:_____

Preferred Name:_____ ☐Male ☐Female

Home Address: _____ City_____ State_____ Zip_____

Mailing Address: _____ City_____ State_____ Zip_____

DOB: _____ S.S._____ Email:_____

Marital Status:_____ Spouse Name:_____

Home #_____ Cell #_____ Work #_____ Ext_____

Occupation:_____ Employer:_____

Person Responsible for account

☐self (only check if all info is the same as above)

Name:_____ DOB:_____ S.S._____

Address: _____ City_____ State_____ Zip_____

Relationship to patient_____ Employer/Occupation_____

Home #_____ Cell #_____ Work #_____ Ext_____

Dental Insurance

☐ I do not currently have dental insurance

Subscriber's Name _____ Insurance Company_____

Relationship to Patient _____ Policy/Group Number_____

Subscriber's Employer _____ Address _____

Subscriber's SS# or ID#_____ City/St/Zip _____

Subscriber's Birth Date _____/_____/_____ Ins. Phone# (_____)_____

Emergency Contact

Name:_____ Relation:_____

Home #_____ Cell #_____ Work #_____ Ext_____

Help us get to know you

How did you hear about our office?

☐Sign ☐Mailer ☐Website ☐insurance ☐Yellow Pages

☐Other_____ ☐Family / Friend_____

Signature:_____ Date:_____

(Patient or Parent/Guardian)