SmileGeorgia! Dental

A. M. DeLoach, DDS, LLC

Patient Information

Name:_____ (Preferred Name)_____

Address:_____City, State, Zip_____

Phone: (home)_____ (work)_____ (cell)_____

E-mail address:_____

Birthdate:_____ Soc Sec:_____ DL#_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Emergency Contact Name: _____ Phone:_____

Referred by: Insurance _____ Patient _____ (_____) Internet _____ Radio Ad _____ Print Ad_____

Responsible Party Information (if someone other than patient)

Name:_____ (Preferred Name)_____

Address:_____

City, State, Zip:_____

Phone: (hm)_____ (work)_____ (cell)_____

E-mail address:_____

Birthdate:_____ Soc Sec:_____ DL#_____

Primary Dental Insurance Information

Name of Insured:_____ Birthdate:_____ SS#_____

Patient's relationship to Insured: Self ____ Child _____ Spouse _____ Other _____

Name of Insurance Co. _____ Phone:_____

Claims address:_____

Secondary Dental Insurance Information

Name of Insured:_____ Birthdate:_____ SS#_____

Patient's relationship to Insured: Self ____ Child _____ Spouse _____ Other _____

Name of Insurance Co. _____ Phone:_____

Claims address:_____

Pt Signature:_____ Date:_____