Georgia endodontics, Implants and Surgery

3450 Acworth Due West Rd., Ste. 380
Kennesaw, Georgia 30144

PATIENT REGISTRATION FORM

(Please print)

Today's Date _____

PATIENT INFORMATION

Check ☐ Mr. ☐ Ms. ☐ Male ☐ Minor ☐ Single ☐ Divorced ☐ Separated
☐ Mrs. ☐ Dr. ☐ Female ☐ Married ☐ Widowed

Name _____
Last First Middle

Address _____
Street City State Zip Code

Date of Birth _____ Social Security No. _____

Occupation _____

Home Tel _____ Work Tel _____ Mobile _____

Emergency Contact Name _____ Phone Number _____

Whom may we thank for referring you?

_____

Who is your family dentist?

_____

Person Responsible for account _____ Date of Birth _____

Relationship to Patient _____

Home Phone _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Social Security No. _____

Employer _____ Insurance Company _____

Insurance Group No. _____ Insurance Company Phone _____

Insurance Company Address _____

Insured Date of Birth _____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I authorize release of any information relating to this claim. I authorize payment of the dental benefits otherwise payable to me directly to Dr. Cornelious Slaton.

_____
Signature (Patient or guardian if minor)

PAYMENT POLICY

Payment is due at the time treatment is initiated. Payment may be made by Cash, Visa, MasterCard, or Discover Card. I/We understand and agree that any credit granted shall be paid promptly in accordance with terms and agreements, that the credit grantor may add one and one half percent (1 ½%) per month to any balance owed and in the event of default to pay reasonable collection charges and/or court costs and attorney fees.

_____
Signature (Patient or guardian if minor)