Family & Cosmetic Dentistry
Dental Smiles
At Dacula

Welcome to our office! We appreciate the trust you have placed in us and we will make every effort to make your visit to our office pleasant.

Patient Information

Patient Last Name:_____

First Name:_____ MI:_____

Preferred Name:_____

Date of Birth:_____ Sex: M ☐ F ☐

Home Address:_____ City/State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____

E-mail: _____

Best time to Call:_____

Marital Status: Married ☐ Single ☐ Other ☐

Full Spouse Name:_____

SS#(required): _____ Driver's License #:_____

Referred By:_____

Person Responsible for Account:_____

Phone (if different):_____

Work Phone: _____ (ext:_____)
Employer/Occupation:_____

Primary Dental Insurance:_____
Employer:_____

Subscribers Full Name: _____ SS#:_____

Date of Birth: _____

Secondary Dental Insurance:_____
Employer:_____

Subscribers Full Name: _____ SS#:_____

Date of Birth:_____