North Road Famly Dental

2175 North Road SW, Snellville, GA 30078 • Phone 770.972.2000 • Fax 770.979.5000

Patient Information

Patient's Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
What is the best way to contact you? (circle) Home Cell Work Email
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____ Marital Status _____
Social Security # _____ Birthdate _____ Gender Male Female
Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
If patient is a minor, give parent's/guardian's name _____
Have we seen another family member? _____ If so, whom? _____
If patient is a full-time college student, fill in school name _____
Name of nearest relative not living with you _____ Relationship _____
Home Phone _____ Cell Phone _____ Work Phone _____

Person Responsible for Payment if Different from Patient

Name _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____
Social Security # _____ Birthdate _____
Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____

We are complimented that you have selected us to provide dental care for you and your family. Whom may we thank for referring you to our office? _____

TIME IS OF VALUE: We understand everyone's time is valuable. It is important for us to reserve enough time for the treatment of our patients. We also expect this reserved time to be a priority for our patients. In this age of advanced communication, it is unacceptable to cancel or not show for a reserved appointment without adequate notice (48 hours). We reserve the right to charge for the broken or cancelled appointment. This policy has been established to help ensure that appointments are available for patients when needed and to increase efficiency and control costs.

I understand that responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I will be responsible for collection costs up to, but not limited to, 35% and attorney fees (if required) to effect collection of services rendered. There will be a $35.00 charge for returned checks.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

In order to better serve you, please use this space to advise us of any expectations or special requests you may have: _____

_____

Print Patient Name _____ Date _____
Patient, Parent or Responsible Party Signature _____ Relationship to Patient _____