



**PATIENT CONFIDENTIAL REGISTRATION**

PerioAtlanta.com

THANK YOU FOR SELECTING OUR PERIODONTAL HEALTHCARE TEAM. WE ARE HERE TO HELP YOU ACHIEVE YOUR TREATMENT GOALS THROUGH COMPREHENSIVE, COMFORTABLE CARE. TO HELP US MEET ALL YOUR DENTAL HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK US - WE ARE HAPPY TO HELP.

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Name</b> (First, M.I., Last):			<b>Preferred to be called:</b>		
<b>Date of Birth:</b>		<b>SSN:</b>		<b>E-mail:</b>	
<b>Address:</b>			<b>City:</b>		<b>State:</b>
<b>Home #:</b>			<b>Cell#:</b>		<b>Work#:</b>
<b>Preferred way to contact you:</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> E-mail					

<b>Patient's Employer:</b>	<b>Patient's Present Position:</b>
<b>Spouse/Partner's Name:</b>	<b>Spouse/Partner's Phone #:</b>
<b>Spouse/Partner's Employer:</b>	<b>Spouse/Partner's Position:</b>
<b>Emergency Contact:</b>	<b>Phone #:</b>

<b>Who may we thank for referring you?</b>		
<b>General Dentist:</b>		<b>Date of last prophylaxis:</b>
<b>Physician:</b>	<b>Phone #:</b>	<b>Date of last exam:</b>
<b>Comments:</b>		

<b>DENTAL INSURANCE INFORMATION*</b>			
<b>Name of Policy Holder:</b>		<b>Relationship to Patient:</b>	
<b>DOB of Policy Holder:</b>		<b>Policy Holder's SSN:</b>	
<b>Name of Employer:</b>		<b>Work #:</b>	
<b>Insurance Company:</b>		<b>Group Name:</b>	<b>Insurance Payor ID#:</b>
<b>Member ID#:</b>	<b>Group #:</b>	<b>Insurance Phone #:</b>	
<b>Insurance Address:</b>		<b>City:</b>	<b>State:</b>
			<b>Zip:</b>

<b>NOTES:</b>
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**\*INSURANCE:** ALL PROFESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT. WE WILL SUBMIT ALL NECESSARY INFORMATION TO HELP YOU OBTAIN YOUR BENEFITS. IF YOU ARE UNABLE TO PAY YOUR ACCOUNT IN FULL AT EACH VISIT, YOU MUST MAKE ARRANGEMENTS WITH OUR FINANCIAL STAFF BEFORE TREATMENT IS STARTED.