

PATIENT CONFIDENTIAL REGISTRATION

DRS. SUGARMAN AND BRUNNER, LLC

TELEPHONE: (404) 352-3123

WELCOME. 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. If you have any questions or need assistance, please ask us - we are happy to help.

Mr. ___ Mrs. ___ Miss. ___ Ms. ___ Dr. ___

DATE: _____

Married ___ Single ___ Widowed ___

NAME: _____ PREFER TO
BE CALLED: _____
First Middle Last

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SS#: _____ E-MAIL: _____

HOME #: (____) _____ CELL#: (____) _____

WORK #: (____) _____ PREFERRED CONTACT#: HOME ___ WORK ___ CELL ___

PATIENT'S EMPLOYER: _____ PRESENT POSITION: _____

SPOUSE'S NAME: _____ SPOUSE'S WORK #: (____) _____

SPOUSE'S EMPLOYER: _____ POSITION: _____

EMERGENCY CONTACT: _____ PHONE #: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

GENERAL DENTIST? _____ DATE OF LAST CLEANING? _____

PHYSICIAN? _____ PHONE#: _____

COMMENTS: _____

DENTAL INSURANCE INFORMATION*

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ WORK #: (____) _____

INSURANCE COMPANY: _____ GROUP #: _____

INSURANCE ADDRESS: _____ 800# _____

**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. (OVER)*