Dentistry of JOHNS CREEK
COSMETIC & RESTORATIVE DENTISTRY

Robert H. Shackelford, D.D.S., P.C.
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Telephone (770) 442-8472 | Fax (770) 751-6880

PATIENT REGISTRATION AND HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date

Patient's Name

Email Address*

Address

City State Zip

Home Phone # Cell Phone #

Birthdate Age M F

Married Single Widowed Student

If student, Name of School

Patient's Social Security #

Occupation

Employer

Business Address City

Business Telephone # Ext.

Insured's Name

Occupation

Employer

Business Address City

Business Telephone # Ext.

*We will not release your email address or personal information to anyone.

Purpose of Visit

Last Dental Examination was on

Former Dentist

Date of Last X-Rays:

Last FMX or Panorex:

Last Bitewings:

Referred to us by:

Is another member of your family or relative a patient at our office?

Name Relationship

Person to contact for emergency

Home Telephone # Business Telephone #

Address

City State Zip

Closest relative not living with you

Home Telephone # Business Telephone #

Address

City State Zip

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Home Address

City State Zip

Home Phone # Cell Phone #

Relationship to Patient

Business Address

City State Zip

Business Telephone #

Dental Insurance Carrier Name

D.O.B. for Primary Carrier

Insured Group #

Insured's SSN or Member ID #

Additional Notes: _____

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_____

PLEASE SEE OTHER SIDE FOR HEALTH HISTORY INFORMATION. THANK YOU.