

**Walker T. Pendarvis, DMD MHS**  
**PRACTICE LIMITED TO PERIODONTICS and IMPLANTS**

**PATIENT REGISTRATION INFORMATION**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last First M.I.

Sex:  M  F Date of Birth: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated

Soc Sec# \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_ Home Phone# \_\_\_\_\_  
Street

\_\_\_\_\_ Cell Phone# \_\_\_\_\_  
City State Zip

Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_ Ext \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

(If minor) Responsible Party Name \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Responsible Party Address (If different from patient's address):

\_\_\_\_\_ Street City State Zip

(If married) Spouse Name \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Spouse or Resp Party Employed By \_\_\_\_\_ Work Phone# \_\_\_\_\_ Ext \_\_\_\_\_

Name of Referring Dentist or Other Provider \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_  
Name Relationship

**DENTAL INSURANCE**

NAME OF EMPLOYEE OR POLICYHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ SOC SEC# OR POLICY ID# \_\_\_\_\_

NAME OF EMPLOYER OR GROUP NAME \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_ CLAIMS MAILING ADDRESS \_\_\_\_\_

**SECONDARY OR ADDITIONAL INSURANCE (IF APPLICABLE)**

NAME OF EMPLOYEE OR POLICYHOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ SOC SEC# OR POLICY ID# \_\_\_\_\_

NAME OF EMPLOYER OR GROUP NAME \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_ CLAIMS MAILING ADDRESS \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize any insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance regardless of insurance. I also authorize the provider or insurance company to release any information required to process my claims. I authorize the use of this signature on any insurance submissions. I hereby agree that if my bill has to be turned over to a third-party collection agency for non-payment there will be a collection fee added to my bill of 33%. This is pursuant to Georgia Statutory Law O.C.G.A.-13-1-11.

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_\_