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** _____