CAPITAL CITY DENTISTRY OF ATLANTA

(Please Print)

PATIENT INFORMATION

Last name: First: Middle:	Title:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Mobile Phone:	Preferred Name:	Birth date: -- --	Age:	Sex: ❑ M ❑ F

Street address:	City:	State and ZIP Code:

Email Address:	Insurance Subscriber Name: Birth Date: -- --	SSN or Insurance ID #:

Insurance Carrier:	Insurance Carrier Address:	Insurance Carrier Phone: ( )

CONTACT INFORMATION

Name of local friend or relative (in case of emergency):	Mobile Phone: ( )	Work phone: ( )
Pharmacy:	Phone: ( )	
Physician:	Phone: ( )	Fax: ( )
Specialist:	Phone: ( )	Fax: ( )
Other:	Phone: ( )	

HEALTH HISTORY

Medical Conditions	Medications	Allergies

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date: