Hudson Dental Care

4579 South Cobb Drive #500

Smyrna, GA 30080

770-438-1520

Thank you for trusting us with your dental care. We promise to do our best to provide you with the best care available. If you have any questions, please do not hesitate to ask.

Patient Information:

Name: _____ Birthdate: _____ ID# (INS.SS):_____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: _____

Email: _____ Who may we thank for referring you? _____

Home Phone: _____ Cell Phone #1 _____ Cell Phone #2: _____

Employer: _____ Employer Phone#: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone#: _____

Person to contact in case of emergency: _____ Phone #: _____

Responsible Party:

Person responsible for this account: _____ Relation to Patient: _____

Address: _____ Home Phone: _____

Birthdate: _____ Are you currently a patient in our office Yes____ No _____

Employer: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Dental Insurance? Yes _____ No _____ Do you have an insurance card? Yes _____ No _____

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ ID# (INS/SS): _____ Date Employed: _____

Employer Address: _____ Work Phone#: _____

Insurance Company: _____ Group #: _____

Address: City: State: Zip:

Additional Insurance:

Name of Insured: _____ Relation to Patient: _____

Birthdate: _____ ID# (INS/SS) : _____ Date Employed: _____

Employer Address: _____ Work Phone#: _____

Insurance Company: _____ Group #: _____

Address: City: State: Zip:

Hudson Dental Care is HIPAA compliant. Documents and forms are available for review. Signature of Patient signifies acknowledgement of HIPPA laws in effect. Patient understands that insurance payments are received by office as a courtesy and the patient is responsible for the entire bill.

Signature: _____ Date: _____