

Hudson Dental Care

4579 South Cobb Drive #500
Smyrna, Georgia 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: _____ Can Spouse Review your Dental Records? (Yes) or (No)
Main Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Employer Phone Number: _____
Spouse or Parent's Name: _____ Emergency Contact: _____ Phone #: _____

Responsible Party:

Person responsible for this account (Circle) : Self / Spouse / Other: If other please fill in blanks below.
Name: _____ Address: _____ Phone #: _____
Birthdate: _____ Are they a patient in our office (Circle): (Yes) or (No)
Employer: _____ Work Phone #: _____
Email: _____ Cell Phone #: _____

Dental Insurance? (Yes) or (No) Do you have insurance card? (Yes) or (No)

Name of Insured: _____ Relation to Patient: _____
Birthdate: _____ ID#(INS/SS): _____ Date Employed: _____
Employer Address: _____ Work Phone: _____
Insurance Company: _____ Group #: _____
Insurance 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 HIPPA compliant. Documents and forms are available for review. Signature of Patient signifies acknowledgement of HIPPA laws in effect. Signature: _____ Date: _____