

# Welcome to GWINNETT FAMILY DENTAL CARE!

3455 Lawrenceville Hwy  
Lawrenceville, GA 30044

Our goal is to deliver the *best patient care possible!*

## PATIENT'S INFORMATION:

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle

Gender: Male Female Marital Status: Single Married Divorced Widowed

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip Code

Email Address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

## INSURED'S INFORMATION: Relationship to Patient: Self Husband Wife Mother Father

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First Middle

Gender: Male Female Marital Status: Single Married Divorced Widowed

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt # City State Zip Code

Email Address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

## INSURANCE INFORMATION:

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Phone #: \_\_\_\_\_

## EMERGENCY CONTACT:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

REFERRAL SOURCE: (Circle One) Yellow Pages Insurance Company Newspaper Radio TV  
Friend or Family Member: \_\_\_\_\_

I understand I am financially responsible for all charges and my insurance claim is filed as a courtesy. I understand after 90 days any outstanding balance becomes my responsibility along with 18% APR interest, which accrues after 90 days. My insurance policy is an agreement between me and my insurance company. I understand Gwinnett Family Dental Care will assist me in getting my claim paid and maximizing my insurance benefits. Payment is expected when services are rendered in the form of cash, check, Visa, Mastercard, Discover, American Express or CareCredit. I give consent to Gwinnett Family Dental Care to release information in order to get my insurance claim paid.

Responsible Party's Signature: \_\_\_\_\_