Darron R. Alvord, DMD, Aaron B. Rawlings, DMD
Savannah Perio and Implants, P.C.

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** _____