BRIGHTEN YOUR SMILE
DENTISTRY

Dr. Keith Shepard

Patient Registration

*Please note: If patient is a minor, we MUST have parents' patient information form on record even if parents are not patients.

Patient Name_____ Date_____

Last First MI (Preferred Name)

Address:_____

Street Apartment #

_____

City State Zip Code

Social Security#_____ Birth Date_____

☐Male ☐Female ☐Married ☐Single

Driver's License #_____ E-mail Address:_____

Phone #'s: Home_____ Work_____Ext_____ Fax_____

Best time to call_____Other _____

Referral Information:

Name_____ Internet_____ Other_____

Spouse or Responsible Party Information:

Name**:**_____

Last First MI (Preferred Name)

Address:_____

Street Apartment #

_____

City State Zip Code

Social Security#_____ Birth Date_____

KEITH SHEPARD, DDS PC
705 Windy Hill Rd SE, Smyrna, GA 30080
770-801-1641
www.smilesmyra.com

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DENTISTRY

☐Male ☐Female ☐Married ☐Single

Driver's License #_____ E-mail Address:_____

Phone #'s: Home_____ Work_____Ext_____Fax_____

Best time to call _____ Other_____

EMPLOYMENT INFORMATION

The following is for: ☐the patient ☐the person responsible for payment

Employer Name:_____

Address: _____

Street City State Zip Code Phone

Form of Payment: ☐ Cash ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ Insurance

Payment is expected at time of service.

INSURANCE INFORMATION

Name of insured:_____

Last First MI

Insured's Birth Date:_____ID#:_____Group #_____

Insured's Address:

_____

Street City State Zip Code

Insured's Employer Name and Address: _____

_____

Street City State Zip Code

Patient's relationship to insured : ☐Self ☐Spouse ☐Child ☐Other

Patient or Guardian's Signature_____**Date**_____

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