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NEW PATIENT INFORMATION

Personal Information

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ ( ) Male ( ) Female ( ) Single ( ) Married

Name of Spouse: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Employer: \_\_\_\_\_ Your occupation: \_\_\_\_\_

Responsible Party

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Insurance Information

Insured's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Group Number: \_\_\_\_\_ Employee ID No. \_\_\_\_\_

How Can We Contact You?

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Email Address: \_\_\_\_\_

Where do you prefer to receive calls? ( ) Home ( ) Work ( ) Cell ( ) Pager ( ) Email

When is the best time to reach you during business hours? \_\_\_\_\_

Authorization and Release

I authorize Amy Russell, DMD to release any information concerning my dental treatment, or my child's, to a third party payors and/or health practitioners.

Signature of patient or parent: \_\_\_\_\_

Doctor signature: \_\_\_\_\_

Date: \_\_\_\_\_