Legacy Dental
601 Dixie Street
Carrollton, GA 30117

Todays Date:____/____/_____

Patient Name:_____

Mailing Address_____Apt:_____

City_____State_____Zip Code_____

Birthdate:____/____/_____Male___Female____Social Number____/_____/_____

Home Phone_(____)_____-_____**Cell Phone**_(____)_____-_____

E Mail Address:_____Primary Physician _____

Emergency Contact:_____Phone_(____)_____-_____

Employer:_____

Status: Married___ Single___Minor___Divorced___

Spouse's Name:_____

Insurance Information

Primary Dental Insurance:_____

Group #_____ID#_____

Address:_____

City_____State_____Zip Code_____Phone #_(____)____-_____

Subscribers Name:_____Date of Birth_____/____/_____

Subscribers Employer:_____Relation to Insured_____

Secondary Insurance:_____