WEST COBB PERIODONTICS
AND IMPLANT DENTISTRY

PATIENT REGISTRATION

Date: ______________________________ Cell Phone #: ______________________

Patient: ___________________________ M ☐ F ☐ Non-Binary ☐

prefer to be called: ____

DOB: ______________________________ Age: ____________________________

Soc Sec # (used for Insurance ID)___________________________________

Full Address: ____

Email: ____

Employer Name: ____

Office Number: _______________________ Position: ___________________

Whom may we thank for referring you?: _______________________________

General Dentist Name ____

General Dentist # ____

Spouses Name/ DOB: ____

Employer: ____

Spouse's daytime #: __________________ Occupation: _________________

Parent/Guardian of Patient (if under 18): ___________________________

Parent/Guardian DOB: ____

Parent/Guardian Address (if different): ____________________________

INSURANCE

We don't not have a contract with any insurance carrier. Insurance policies are contracts between the patient/employer and the carrier only. Amounts due are the full responsibility of the patient/guardian We offer insurance billing help as a courtesy to our patients to help you file the claim. You must fill out all the necessary fields for us to be able to file your insurance claim for you properly. All fees are due at time of service and the insurance company will reimburse you for whatever their fees are which will be reimbursed to by check to your home. When scheduling surgeries, we do sometimes ask for a deposit to be able to hold longer appointments and secure you a spot. In the event of a cancellation, we will need 48 hours notice prior to the appointment. cancellations less then 48 hours will be charged a $75 non-refundable fee. By signing below, you agree to these terms.

Primary Insurance Name: ____

Dental Claims Mailing Address: ______________________________________

Subscribers Name and Address: _______________________________________

Subscribers DOB: ____

Relationship to Subscriber: ____

Patient ID#: ____

Group Number: ____

Signature: __________________________ Date: _________________________