

North Georgia Dentures and Implants

Patient History Information

****WE DO NOT ACCEPT DENTAL or MEDICAL INSURANCE****

Name: _____

Today Date: _____ Sex: M / F Date of Birth: ____/____/____

Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone# _____

Work Phone: _____ Cell. Phone: _____

What is the reason for today's visit? _____

How did you find out about our office? _____

Who is your present dentist? _____

Are you taking or have you ever taken prescription medication for Osteoporosis (bone loss)? Y/N
If yes, please specify: _____

OUR PAYMENT POLICY

We gladly accept payment by CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS.

WE DO NOT ACCEPT CHECKS.

WE DO NOT FILE INSURANCE, BUT WILL GLADLY PRINT AN INSURANCE FORM FOR YOU TO FILE.

