Stockbridge Dental, LLC
150 Country Club Drive, Suite 201
Stockbridge, GA 30281

Welcome to Dr. Felcher's Office

ABOUT YOU

Patient's Name:_____ MALE ☐ FEMALE ☐

Address:_____ Apt #:_____ City:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell #:_____ Birthdate:_____

Other members of your family seen by our office? _____

Emergency Contact:_____ Phone #:_____

IF PATIENT IS AN ADULT

Employer:_____ Spouse's Name:_____

Position:_____ Employer:_____

Phone #:_____ Phone #:_____

Social Security #:_____ Social Security #:_____

IF PATIENT IS A CHILD

Father's Name:_____ Mother's Name:_____

Address (If different from above): Address (If different from above):

_____ _____

Date of Birth:_____ SS#:_____ Date of Birth:_____ SS#:_____

Employer:_____ Employer:_____

Position:_____ Position:_____

Phone #:_____ Phone #:_____

DENTAL INSURANCE

Primary Ins. Co.:_____ Secondary Ins. Co.:_____

Address:_____ Address:_____

Insured's Name: _____ Insured's Name:_____

Policy/Group #: _____ Policy/Group #:_____

Person responsible for account:_____ Phone #:_____

Billing Address (If different from above):_____

Date you last saw a dentist:_____ Dentist's Name:_____

Who may we thank for referring you?_____

☐ Internet
☐ Yellow Pages
☐ Walk in
☐ Friend/Family
☐ Other

I AUTHORIZE MY INSURANCE COMPANY TO PAY STOCKBRIDGE DENTAL, LLC BENEFITS THAT OTHERWISE ARE PAYABLE TO ME DIRECTLY.

Patient (or guardian) Signature:_____ Date _____