Dr. Pallavi Rakesh

3450 Old Milton Pkwy, #110
Alpharetta, GA 30005

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Patient Update

Fields Marked With An * Are Required

Name: ____
Last* First* MI Title

Preferred Name: ______________________________ ❑ Male ❑ Female

Address: ____________________ City ______________ State ______ ZIP__________

SSN: ____________________ DOB* (M/D/YYYY): ____________________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ E-mail Address: ____________________

Employer:____________________ Occupation: ____________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

Do you prefer to be contacted for appointment confirmation via ❑ e-mail or ❑ phone? *(Please check preference)*

Medical History Update

Has there been any change in your health since your last appointment? ❑ Yes ❑ No

If yes, please explain: ____________________

Are you taking any kind of medication at this time? ❑ Yes ❑ No

If yes, please list each one: ____________________

Do you have any allergies to medications? ❑ Yes ❑ No

If yes, please list them: ____________________

Have you been hospitalized within the past few years? ❑ Yes ❑ No

If yes, please explain: ____________________

Women: Are you pregnant? ❑ Yes ❑ No Due Date: __________

Insurance Information

Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber Name: ____________________ Subscriber DOB: __________

Subscriber SSN/ID: ____________________ Subscriber Employer: ____________________

Insurance Company Name: ____________________

Insurance Company Phone: __________ Group Number: __________ Group Name: __________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Ace Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship: ______________ Date: __________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature Date: __________

Doctor Signature Date: __________