ACE FAMILY DENTAL CARE
Family, Implant and Cosmetic Dentistry
Website: www.acefamilydental.com

ALPHARETTA OFFICE
3450, Old Milton Pkwy,
#110, Alpharetta, GA 30005
Ph: (678) 562-1555, Fax: (678) 562-1556
Email: frontdesk@acefamilydental.com

NORCROSS OFFICE
3985, Steve Reynolds Blvd,
Suite K101, Norcross, GA 30093
Ph: (770) 806-1255, Fax: (770) 806-1254
Email: norcross@acefamilydental.com

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 conf rmation 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: _____