☐ **Ed Fernandez, Jr., DMD** ☐ **John F. Sigman, DMD**

3408 University Avenue Suite E • Columbus, GA 31907

Welcome

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If yu have any questions or need assistance, please ask us- we will be happy to help.

ALL INFORMATION MUST BE COMPLETED

Date:_____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Email _____ Cell Phone _____ Preferred Contact_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Gender ☐ Female ☐ Male

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in Case of emergency _____ Phone _____

Whom May We Thank for referring You? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ SS# _____ Employer _____ Work Phone _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment: Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ Mastercard ☐ Discover ☐ Care Credit

Insurance Information

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Policy Holders Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Ins Co Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No ***IF YES*, COMPLETE THE FOLLOWING**

Name of Policy Holder _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Policy Holders Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Ins Co Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How Much Have You Used? _____ Max Annual Benefit _____