

# Welcome to Our Practice

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[www.collinshilldental.com](http://www.collinshilldental.com)

Phone: (770) 962 - 3191  
Fax: (770) 962 - 3145

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
First Middle Initial Last Month Day Year

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_ Married/ Single Male / Female  
City State Zip

Home Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

## **ACCOUNT INFORMATION**

Person Responsible for the Account: \_\_\_\_\_  
Name Date of Birth Relationship to Patient

Billing Address (if different than above): \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
Date of Birth

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group/Plan/Policy #: \_\_\_\_\_

>Previous Dentist: \_\_\_\_\_  
Name Address Phone #

>Date of Last Visit: \_\_\_\_\_

>Whom may we thank for referring you to our office? \_\_\_\_\_

>May we contact you at your work number to confirm your appointments? Yes No

>Emergency Contact: \_\_\_\_\_  
Name Relationship Phone Number