770.992.6568
www.drshenk.com

SHENK DENTAL CARE

Judd W. Shenk, DMD

Welcome!

We are pleased to welcome you to our practice.
Whom may we thank for referring you? _____
Are any relatives patients of ours? _____

Patient Information

Name _____ Today's Date ____/____/_____
Address _____ Birthdate ____/____/_____
City _____ State ___ Zip _____ ___ Male ___ Female ____ Child

Home phone _____ Cell phone _____ Work phone _____
SS# ____- ___ - _____ Email _____

Employer (skip if child) _____ Occupation _____ # yrs __
Business address _____

Notify in case of emergency _____ Day phone #_____

Spouse Information

Name _____ Birthdate ____/____/_____
Employer _____ Work phone _____
SS# ____-___ -_____ Cell phone _____

Responsible Party/Primary Insurance Coverage

Name _____ Birthdate ____/____/_____
SS# ____-___ -_____ Relationship to patient _____
Address (if different) _____
Home phone _____ Cell phone _____ Email _____
Employed by _____ Occupation _____ # yrs __
Business address _____
Insurance Carrier_____
Policy # _____ Group # _____

Secondary Insurance Coverage

Name _____ Birthdate ____/____/_____
SS# ____-___ -_____ Relationship to patient _____
Address (if different) _____
Home phone _____ Cell phone _____ Email _____
Employed by _____ Occupation _____ # yrs __
Business address _____
Insurance Carrier_____
Policy # _____ Group # _____