



Shoemaker Pediatric Dentistry

SHOEMAKER PEDIATRIC DENTISTRY

ANDREW SHOEMAKER, DMD
3745 CHEROKEE ST. SUITE 901
KENNESAW, GA 30144
PHONE: 678.303.1414
FAX: 678.303.3337

INFO@SHOEMAKERPEDIATRICDENTISTRY.COM
WWW.SHOEMAKERPEDIATRICDENTISTRY.COM

PATIENT REGISTRATION

THANK YOU FOR VISITING OUR OFFICE! PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. IF YOU HAVE ANY QUESTIONS, WE WILL BE HAPPY TO HELP!

HOW DID YOU HEAR ABOUT US? FACEBOOK INTERNET NEWSLETTER INSURANCE SEARCH
OTHER: _____

PATIENT INFORMATION:

NAME: _____
LAST FIRST MI

GOES BY: _____ MALE FEMALE

SIBLINGS WE TREAT: _____

BIRTH DATE: _____ AGE: _____

SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____
CITY STATE ZIP

HOME PHONE: _____

FAVORITE MOVIE: _____

FAVORITE ACTIVITY: _____

PARENT ONE:

NAME: _____
LAST FIRST MI

RELATIONSHIP: MOTHER FATHER

WK PH: _____ CELL PH: _____

EMAIL: _____

PREFERRED CONTACT METHOD:

HM PHONE WK PHONE CELL TEXT MSG EMAIL

PREFERRED CONTACT METHOD FOR CONFIRMATIONS:

HM PHONE WK PHONE CELL TEXT MSG EMAIL

DENTAL INSURANCE: (PRIMARY)

INSURANCE COMPANY NAME: _____

ADDRESS: _____

PHONE NUMBER ON CARD: _____

EMPLOYER: _____ GROUP NAME: _____

GROUP #: _____ MEMBER #: _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: SELF PARENT SPOUSE

POLICY OWNER'S DOB: _____

SSN: _____

WHO IS ACCOMPANYING YOUR CHILD TODAY?

NAME: _____
LAST FIRST MI

RELATIONSHIP: _____

DO YOU HAVE LEGAL CUSTODY OF YOUR CHILD?

YES NO

IS THERE ANYONE YOU WOULD LIKE TO DESIGNATE TO BRING YOUR CHILD FOR APPTS? IF YES, PLEASE LIST:

NAME: _____
LAST FIRST MI

RELATIONSHIP: _____

NAME: _____
LAST FIRST MI

RELATIONSHIP: _____

PARENT TWO:

NAME: _____
LAST FIRST MI

RELATIONSHIP: MOTHER FATHER

WK PH: _____ CELL PH: _____

EMAIL: _____

PREFERRED CONTACT METHOD:

HM PHONE WK PHONE CELL TEXT MSG EMAIL

PREFERRED CONTACT METHOD FOR CONFIRMATIONS:

HM PHONE WK PHONE CELL TEXT MSG EMAIL

DENTAL INSURANCE: (SECONDARY)

INSURANCE COMPANY NAME: _____

ADDRESS: _____

PHONE NUMBER ON CARD: _____

EMPLOYER: _____ GROUP NAME: _____

GROUP #: _____ MEMBER #: _____

POLICY OWNER'S NAME: _____

RELATIONSHIP TO PATIENT: SELF PARENT SPOUSE

POLICY OWNER'S DOB: _____

SSN: _____