Acworth Premier Dental Care
4343 South Main St.
Acworth, GA 30101
(770) 974-6868

New Patient Information

Name__________________________________

Cell#____________________Email____

DOB_______________

Insurance Company________________________________

Insurance Phone#__________________________________

Policy holder_____________________________________

DOB of insured___________________________________

Member ID_______________________________________

Employer or Group name___________________________

Who may we thank for referring you?____

What type of dental service are you interested in?______________________________

How long has it been since you have seen a dentist?____________________________

Have you noticed any problems with your teeth?_______________________________

Why did you leave your last dentist?____

Previous dentist Name/#/ Previous X-rays_____________________________________

Who else can we schedule in your family?____________________________________