Edward C. Smith, DMD, MPH, LLC
5650 Whitesville Road, Suite 101
Columbus, GA 31904
(706) 494-5886

Patient Information

You must be 18 years or older to complete this form

Today's Date: ______________________________

Patient's Name ______________________________ Preferred Name ________________
Address ______________________________ City/St/Zip ____________________
Birthdate ____________________ Social Security # ______________________
Home # ________________ Work # ____________________ Cell # ________________
Employer ______________________________ Occupation ____________________

Spouse's Name ______________________________ Birthdate ________________
Spouse's Employer ______________________ Occupation ______________________
Spouse's Social Security # ______________________ Work # ________________

Closest relative not living with you ______________________________________
Emergency Contact ______________________________ Phone # ________________
Relationship ______________________________

Insurance Information

Who is the subscriber (person) the insurance is under? ______________________
Name of Insurance ______________________ ID#(on card) ____________________
Policy# (on card) ______________________ Group #(on card) ________________
Insurance company address and phone # :

____

____

Are there any dependents covered under this policy? ____________ Y ____________ N
If yes, please name all, along with birthdates for each:

____

____

____