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NEW PATIENT INFORMATION

Personal Information

Name: _____

Social Sec. #: _____ Birth Date: _____

Wish to be called: _____ () Male () Female () Single () Married

Name of spouse: _____

Address: _____

City/State/Zip: _____

Who may we thank for referring you to our office? _____

Employer: _____ Your occupation: _____

Responsible Party

Name: _____ Relation to patient: _____

Birth Date: _____ Social Sec. #: _____

Name of spouse: _____

Employer: _____ Occupation: _____

Address: _____

City/State/Zip: _____

How Can We Contact You?

Home Phone: _____ Work Phone: _____ Ext. _____

Cell Phone: _____ Pager: _____

Email Address: _____

Where do you prefer to receive calls? () Home () Work () Car () Pager () Email

When is the best time to reach you? _____

Authorization and Release

I authorize Dr. Rodgers or his employees to release any information concerning my dental treatment, or my child's, to third party payors and/or health practitioners.

Signature of patient or parent: _____

Doctor signature: _____

Date: _____