DAVID K BURAN
DENTISTRY

GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Date of Birth: _____

Marital Status: Single Married Separated Divorced Widowed

Sex: Male Female

Social Security Number: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Home Address:

Address: _____

City, State and ZIP: _____

Billing Address:

Address: _____

City, State and ZIP: _____

Work Information

Employer: _____

Occupation: _____

Work Phone Number: _____

Method of Contact: Phone Email Text Message Any of the previous ones

Emergency Contact:

Full Name: _____

Phone Number: _____

Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

Dr. David Buran
Phone: 770.943.0701

85 Golf Crest Dr #105,
Acworth, GA 30101

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____

Social Security: _____

Relation to Patient: _____

Patient's Student Status

Student Status: _____

College: _____

College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

Social Security: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

Social Security: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

Dr. David Buran
Phone: 770.943.0701

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