



Amy Mathew D.M.D.

2883 North Decatur Road Decatur, Georgia 30033

404-299-7411

Patient Registration

First Name: Last Name:

Patient is: Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name:

Address:

City: State: Zip:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc. Sec: Drivers Lic:

Responsible Party is Also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Ext: Cellular:

Sex: Male Female Preferred Pronoun: he/him she/her they/them

Marital Status: Married Single Divorced Separated Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: I would like to receive correspondences via e-mail

Primary Insurance Information

Name of Insured:

Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured:

Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: .00 Rem. Deduct: .00

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Date: