



DENISE ALLEN BROWN, DMD
FAMILY DENTISTRY

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WELCOME!

(CONFIDENTIAL INFORMATION)

Today's Date: _____

Name: _____
First MI Last

Birth Date: _____
M D Year

Address: _____
Street Apt.
City State Zip

SS #: _____

Married/Single Male/Female

Home Phone: (____) _____

Cell phone _____

Work Phone: (____) _____

May we contact you at work? Y or N

E-mail address: _____

Employer: _____

Employer Address: _____

- Previous Dentist: _____ Date of last visit _____
- Whom may we thank for referring you? _____
- Which is best to confirm appointments? CIRCLE: Home Work Cell E-mail
- Emergency contact: _____
(Name/ Relationship/ Phone Number)

ACCOUNT INFORMATION

Person Responsible for this Account: _____

Billing Address (if different than above): _____

Insured Person's Name: _____ SS#: _____

Employer: _____ Phone #: _____

Insurance Company: _____

- Please present your dental insurance card for photocopying

Insurance Company Address: _____

Insurance Company Phone #: _____

Group / Plan/ Policy #: _____

Denise Allen Brown, DMD

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