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2556 Apple Valley Road  
Suite 150  
Atlanta, GA 30319

**P A T I E N T   R E G I S T R A T I O N**  
(PLEASE PRINT)

Patient's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Work Phone \_\_\_\_\_  
(ss# necessary if you want us to file insurance claim)

Date of Birth \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP

General / Referring Dentist Name \_\_\_\_\_

\*\*\*\*\* If different from the patient, please fill out the information below \*\*\*\*\*

Person Responsible for Account \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient:    Spouse    Parent    Other

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Treatment Information**

I understand that Root Canal Treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Treatment has a very high degree of clinical success, it is still a biological procedure, and cannot be guaranteed. Occasionally a tooth may require Re-Treatment, surgery or even extraction, which will incur an additional charge. I also understand that only the Root Canal Treatment is performed at this office. The permanent restoration (filling, crown, bridge, etc.) will be done by my general dentist.

**Payment Method**

I understand that this office will file an insurance claim on my behalf as a courtesy. I am responsible for any remaining balance due after the insurance settlement. I also understand that I have two options: Providing credit card information to automatically be billed in the event insurance pays less than the remaining balance due, or paying the amount in full at the time of service. (If full payment is made, insurance re-imbusement will be sent to me for any covered benefits.)

\*\*\*\*The fees for all consultations must be paid in full at the time of service\*\*\*\*

Please circle your payment method below

Cash      Check      Debit Card      M/C      Visa      Discover      AmEx

Signed \_\_\_\_\_ Date \_\_\_\_\_