Akron
Periodontics & Dental
Implantology

**Khawla AlJohani, D.D.S., M.S.D.**
**Mark S. Obernesser, D.D.S., M.M.Sc.**
484 S. Miller Rd
Fairlawn, OH 44333
T 330.867.3320
F 330.867.3339

---

**New Patient Registration Form**

**Welcome to Akron Periodontics and Dental Implantology! Please complete the following form to the best of your ability. All information will be kept confidential.**

**Patient Information**

**Full Name:** _____

**Date of Birth:** _____

**Gender:**
☐ Male
☐ Female
☐ Prefer not to answer

**Social Security Number:** _____

**Address:**
Street Address: _____
City: _____
State: _____
Zip Code: _____

**Phone Number:**
☐ Home: _____
☐ Mobile: _____
☐ Work: _____

**Email Address:**_____

**Emergency Contact Information**

**Emergency Contact Name:**_____

**Relationship to Patient:**_____

**Emergency Contact Phone Number:**
☐ Home: _____
☐ Mobile: _____
☐ Work: _____

---

**Insurance Information**

**Primary Insurance Provider:** _____

**Policy Number:** _____

Group Number: _____

**Subscriber's Name (if not the patient):** _____

**Subscriber's Date of Birth (if not the patient):** _____

**Relationship to Patient:**
☐ Self
☐ Spouse
☐ Parent
☐ Guardian
☐ Other: _____

**Secondary Insurance Provider (if applicable):** _____

**Policy Number:** _____

**Group Number (if applicable):** _____

**Preferred Appointment Information**

**Preferred Appointment Time:**

☐ Morning

☐ Afternoon

☐ Evening

---

**Acknowledgments**

By signing below, I acknowledge that the information provided above is accurate and complete to the best of my knowledge. I consent to the use of this information for medical and administrative purposes.

**Printed Name:** _____

_____

**Signature of Patient or Legal Guardian** **Date**