Implants & Periodontics, LLC

PATIENT INFORMATION FORM

Date_____

Name_____

Home Phone_____ Work Phone _____ Cell Phone _____

Address_____ City_____ Zip _____

Birth date_____ Marital Status _____Social Security #_____

Employer_____ Occupation _____

Work address_____ City_____ Zip _____

Spouse's Employer_____Occupation _____

Spouse's work address_____ City _____ Zip _____

Dentist_____ Years_____

Referred by _____

Who will be responsible for this account? _____

Emergency Contact and Phone #:_____

EMAIL ADDRESS:_____

PATIENTS WITH DENTAL INSURANCE

Insured Person_____ID# or Social Security #_____

Name of Plan_____ Plan # _____

Do you have secondary dental insurance? _____ *If yes, please continue:*

ID# or Social Security # _____ Birth date _____

Name of Plan _____ Plan # _____

FINANCIAL POLICY

It is our policy that billing procedures be clearly understood prior to the onset of treatment. Payment is expected at the time of treatment. Payment may be made by cash, personal check or credit card. Extended payments may be available through prior financial arrangements with our office manager. Any balance reflected in your statement is due within 10 days of receipt of your statement. Monthly bookkeeping fees may be applied to unpaid balances.

If you have dental insurance we will bill your primary insurance company, as a courtesy to you. Complete insurance information must be provided at the time of your first visit. All deductibles and copayments are due at the time of treatment. Please note that dental insurance is designed to help pay part of the cost of treatment. Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated and we cannot guarantee payment of your claims. We will be glad to assist you in filing for these benefits, but you are ultimately the one who is financially responsible for your treatment.

If you are unable to keep your appointment, please call us as soon as possible or leave a message if the office is closed. *A fee is assessed for missed/broken appointments without 24-hour notice.* Please understand this policy is necessary so that we may make this time available to other patients who are waiting for an appointment.

In the event that it becomes necessary to place an account in collections, the patient is responsible for any additional legal and collection related costs that may be incurred. By signing below you indicate that you have read the preceding and understand that periodontal services are rendered in accordance with these terms.

I acknowledge I have reviewed a copy of this office's Notice of Privacy Practices.

_____
Patient Signature

_____
Patient Signature