

WELCOME TO OUR OFFICE PERIODONTAL ASSOCIATES

Date _____

Patient's Name _____

Nickname _____

Date of Birth _____

Social Security # _____

Name of Spouse _____

Spouse Social Security # _____

If a Child, Parent's Name _____

Residence Address _____ Apt. _____

City _____ State _____ Zip _____

Telephone: Residence (____) _____ Cell (____) _____ Business (____) _____ Ext. _____

E-Mail Address _____ Fax No. _____

Please check where you want us to confirm your appointments: ☐ Residence ☐ Cell ☐ Business ☐ E-Mail

Employed By _____ Position _____

Business Address _____ City _____ State _____ Zip _____

Spouse Employed By _____ Business Phone _____

Whom may we thank for referring you? _____

Who is your general dentist at this time? _____

Nearest relative not living with you _____

Contact in case of emergency _____ Telephone # (____) _____

Person responsible for payment of account _____

(name, address, telephone if different than above)

DENTAL INSURANCE

Primary Dental Insurance

Your dental insurance is through (check one):

____ your employer ____ your spouse's employer ____ other

Employee's Full Name: _____

Employee's Date of Birth _____

Employee's Social Security # _____

Employer's Name _____

Employer's Address _____

Insurance Name _____

Insurance Address _____

Policy # _____ Group # _____

Employer ID# _____ Union Local # _____

Insurance Co. Phone (____) _____

Secondary Dental Insurance (if you have dual coverage)

Your dental insurance is through (check one):

____ your employer ____ your spouse's employer ____ other

Employee's Full Name: _____

Employee's Date of Birth _____

Employee's Social Security # _____

Employer's Name _____

Employer's Address _____

Insurance Name _____

Insurance Address _____

Policy # _____ Group # _____

Employer ID# _____ Union Local # _____

Insurance Co. Phone (____) _____

I understand that I am responsible for all costs of dental treatment and accept that should collection proceedings be instituted, attorney fees, collection expenses, interest and court costs will be imposed. I hereby authorize the release of any dental or medical records as necessary to assist in dental treatment and/or relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Periodontal Associates to submit claims for benefits and services rendered or to be rendered and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize and assign direct payment of the dental benefits for such services otherwise payable to me, directly to Dr. Versman, Dr. Heller, Dr. Glick or Periodontal Associates. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's/Parent's Signature _____

Reviewed By _____ Date _____

