Jeremy I Factor, DDS MPH ~ Diplomate, American Board of Periodontology
~Periodontics and Implant Dentistry~

INTRODUCTORY INFORMATION

~~YOUR INFORMATION~~

Last_______________________________ **First**________________ **MI**___ **SEX: M F** **Birthdate** _____________ **Age**_____

☐**Child If minor patient provide name of parent or guardian**____

Who may we thank for referring you to us?______________________________ **Reason for visit today**__________________

~~RESPONSIBLE PARTY (YOU OR PARENT IF MINOR CHILD) INFORMATION~~

☐ **Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widowed**

NAME Last____ **First**________________ **MI**___ **Birthdate**____________________

HOME Street____**Apt**____**City**_________________**State**________**Zip**________

MAIL ADDRESS (IF DIFFERENT)____

HOME PHONE___________________ **WORK PHONE**____________________**EXT**______ **CELL PHONE**__________________

SOC SEC#_______________________ **DRIVER'S LIC#**________________ **RELATION TO PATIENT**_____________________

EMPLOYER_______________________**OCCUPATION**___________________**EMAIL ADDRESS:**______________________

~YOUR SPOUSE (or additional parent) INFORMATION~~

NAME____
Last First MI

SOC SEC#_________________**BIRTHDATE**______________

EMPLOYER____

WORK PHONE_______________**DRIVERS LIC#**__________

~~EMERGENCY INFORMATION~~

NAME____

PHONE____

ADDRESS_______________________________________

RELATIONSHIP___________________________________

~~PRIMARY DENTAL INSURANCE INFORMATION~~

INSURED IS: ☐**SELF** ☐ **SPOUSE**

INS COMPANY_____________________________________

GROUP#________________**TELEPHONE#**______________

~~SECOND DENTAL INSURANCE INFORMATION~~

INSURED IS: ☐**SELF** ☐ **SPOUSE**

INS COMPANY_____________________________________

GROUP#________________**TELEPHONE#**______________

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount(s) due on my claim for services rendered to my dependent or me. I further agree that should the amount be insufficient to cover the entire dental and surgical expense, I will be responsible for the payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill. I authorize release of pertinent information.

SIGNED____ DATE__________________

. . . .

We anticipate that you will make every effort to keep your appointments and give us at least **24** hours notice of your need to change an appointment. In the case of a surgical appointment **48**-hour notice is required. **Cancellations must be made during office hours with a staff member.** This will prevent a charge being made to your account. The first broken appointment charge is a minimum of 50% of the appointment value. Thereafter the charge will be the full value of the missed appointment.

All Accounts Are Due At The Time Service Is Rendered Unless Prior Arrangements Are Made

Charges not paid within ninety (90) days may be subject to a "LATE PAYMENT" fee of 1.5% per month (18% annual percentage rate) until paid in full. Future services may be refused until the amount outstanding is no longer delinquent. Minimum "LATE PAYMENT" fee is fifty (.50) cents. If it is desired to extend payments for more that 30 days, specific arrangements need to be made with our office. These extended payment courtesies are made provided payments are received as promised. Failure to pay will result in a collection service being used. The expense of legal fees and collection service is the responsibility of the patient or account holder. There is a twenty ($20) dollar charge for checks returned by your bank. In the event that court action is necessary, triple damage will be assessed.

I have read the above and understand that I am responsible for all charges incurred.

SIGNED____ DATE__________________

. . . .

PERMISSION FOR TREATMENT: This is my consent for the use of local anesthetic, sedation or analgesia and any other procedures that the judgment of Jeremy Factor, DDS MPH may dictate during the treatment period.

SIGNED____ DATE__________________