Periodontal Health Professionals

Patient Information

Date___________

PATIENT'S NAME____ Nickname____________________________

Home Address____ Apt.#________________

City_____________________________ State_________ Zip____________ Home Phone_________________________

Social Security No.__________________ Date of Birth__________________ Driver's License #______________________

Employer____ Business Phone______________________ Ext._________

Occupation____ Cell Phone _____________________________________

Would you like to be contacted via e-mail?   YES   NO   E-mail Address:____

Spouse's Name____ Bus. Phone__________________________

Spouse's Employer____

PERSON TO CONTACT IN AN EMERGENCY____

Relationship_________________________ Home Phone________________________ Bus. Phone___________________

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT____

(NOT your insurance carrier)

Social Security No.________________________ Home Phone______________________ Bus Phone__________________

ARE YOU COVERED BY A DENTAL INSURANCE PLAN?   YES   NO

IF YOU ARE COVERED UNDER A **DENTAL** INSURANCE PLAN, PLEASE COMPLETE THE FOLLOWING:

We will be unable to file your insurance unless this is properly and fully completed. Please complete only if this is dental insurance, and it is your primary carrier.

Name of Insured____ Relationship__________________________

Social Security No. of Insured_________________________________ Birth Date of Insured_______________________

Insurance Co. Name____ Policy or Group No.__________________________

Insurance Co. Address____

City______________________________ State_________ Zip__________ Phone________________________________

Employer of Insured_________________________________ Employer Address__________________________________

YOUR SIGNATURE IS REQUIRED IN ORDER FOR US TO:

1. **Process all insurance claims**
2. **Extend credit to you for services rendered (when applicable)**
3. **Ensure payment for services rendered**
4. **Release medical information to insurance companies**
5. **Release information to other medical/dental providers, when necessary**
6. **Acknowledge that you have received a copy of this office's Privacy Practices as required by HIPAA.**

I authorize the release of all medical/dental information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all dental/medical benefits, including major medical benefits to which I am entitled, to Periodontal Health Professionals for their services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that my dental insurance carrier may pay less than the actual amount charged for services. I understand that I am fully responsible for any and all payments due on my account. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my insurance provider.

Patient Name_____________________________________ Signature___________________________________

Responsible Party_________________________________ Signature___________________________________