Periodontics NW Patient Information

Name _____ Today's date ____/____/___ Sex: M ☐ F ☐

Preferred name _____ Date of birth ___/___/__ Home phone ___(____)_____

Home address _____ Work Phone ___(____)_____

City _____State ____ Zip_____ Cell Phone ___(____)_____

Marital Status: S ☐ M ☐ W ☐ D ☐ Email _____

Employer _____ SS # _____

Occupation _____ Spouse's employer _____

Who referred you to our office? _____

In case of emergency

Spouse's name _____ Phone/cell # __(____)_____

Other than spouse _____ Phone/cell # __(____)_____

Dental Insurance Information

I have no dental insurance ☐

Primary	Secondary
Subscriber's name _____	Subscriber's name _____
Subscriber's date of birth ____/____/_____	Subscriber's date of birth ____/____/_____
Subscriber's SS#: _____	Subscriber's SS#: _____
Insurance Co. _____	Insurance Co. _____
Insurance Co. Address _____	Insurance Co. Address _____
City, St. Zip _____	City, St. Zip _____
Phone # __(_____) _____	Phone # ___(_____)_____
Ins Group # _____	Ins Group # _____

Consent for Services

I authorize Periodontics NW and my dentist(s)/physician(s) to release any and all medical or dental information for evaluation, treatment, and any anticipated care. The above information has my release to forward to my insurance carrier for purposes of claims, administration and evaluation, utilization review and financial audit.

As a condition of your treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½ per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I have read the above conditions of treatment and payment and agree to their content.

x_____ Date: ___/___/___ Relationship to patient: _____

Signature of patient, parent or guardian