Chart #: ____________

Patient Information

Patient Name ______________________________________ Date:____________

Last, First MI (Preferred Name) gender

Social Security #: _____________ Birth Date:_________ Driver's License #:_____________________

Phone (Home): ________________ (Work): _________________ Ext: _________ Cell: ________________________

Address:____

Street City State Zip Code Apartment #

Employer Name: ______________________ E-mail Address: ____

Referred By ____

Responsible Party Information

*** Do not fill out if same as above

Name:,____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________________

Social Security #: ________________________ Birth Date: _______________CDL#____________________________

Phone (Home): ________________ (Work): ________________ Ext: ______ Best time to call: ___________________

Address: ____

Street Apartment # City State Zip Code

Emergency Contact

Name________________________________ Relationship________________________________ Phone #_______________________

Insurance Information

Effective: ______________

Primary

Name of Insured: ____

Last First MI

Insured's Birth Date: ___________________ SS #: _______________________

Insured's Employer Name: ______________________ Group #: ____________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insurance Plan Name and Address: _______________________

____

MAX: $_______________ **IMPLANTS:** ______________

DED: $________ Met / Not Met **NETWORK:** IN / OUT

PERIO%: ________ **Incentive%:** _______UCR / Fee Schedule

YTD: $____________________ **PEND:** $_____________

Used / Remaining

Perio Hx: ________________________________

EXAM: 2 in Cal Yr / 4 in Cal Yr / 2 in 12 mos / 1 in 6 mos / 1 in 166 days **Used:** _______________

PMT: 2 in Cal Yr / 4 in Cal Yr / 2 in 12 mos / 1 in 6 mos / 1 in 166 days **Used:** _______________

Effective: ______________

Secondary

Name of Insured: ____

Last First MI

Insured's Birth Date: ___________________ SS #: _______________________

Insured's Employer Name: ______________________ Group #: ____________

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Insurance Plan Name and Address: _______________________

____

COB: STD / Fee Schedule / Non Duplication

MAX: $_______________ **IMPLANTS:** ______________

DED: $________ Met / Not Met **NETWORK:** IN / OUT

PERIO%: ________ **Incentive%:** _______UCR / Fee Schedule

YTD: $____________________ **PEND:** $_____________

Used / Remaining

Perio Hx: ________________________________

EXAM: 2 in Cal Yr / 4 in Cal Yr / 2 in 12 mos / 1 in 6 mos / 1 in 166 days **Used:** _______________

PMT: 2 in Cal Yr / 4 in Cal Yr / 2 in 12 mos / 1 in 6 mos / 1 in 166 days **Used:** _______________

Consent for Services

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 patient's 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 hereby authorize payment directly to Capitol Periodontal Group of the insurance benefits otherwise payable to me.

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

____ Date: ___________ Relationship to Patient: ________________________

Signature of patient, parent or guardian