

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 # _____
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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: _____

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: _____	

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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.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____