PATIENT INFORMATION FORM

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Diplomate of American Board of Periodontology
Periodontics • Oral Medicine • Dental Implants

(*Please Print)* Date: _____

Name: Dr/Mr/Mrs/Ms _____
First Middle Last

Address: _____

City, State, & Zip: _____

Home Phone: ( ) _____ - _____ Work Phone: ( ) _____ - _____

Cell Phone: ( ) _____ - _____ Email: _____

Employer: _____ Occupation: _____

Birthdate: _____ - _____ - _____ Social Security #: _____ - _____ - _____

Referral Information

Whom may we thank for referring you? _____

Name of General Dentist: _____

Is another family member or relative a patient at our office? Yes ☐ No ☐ Name: _____

Person Financially Responsible for Account

Name: _____ Relationship to patient: _____

Address: _____

Do you have dental benefits? Yes ☐ No ☐ If yes, provide cards to be copied

Primary Insurance Company: _____ Secondary Insurance Company: _____

Employer: _____ Employer: _____

Employee's Name: _____ Employee's Name: _____

Employee DOB: _____ SS#: _____ Employee DOB: _____ SS#: _____

Member ID #: _____ Member ID #: _____

Consent for Treatment

The success of periodontal therapy and implant treatment is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene and to stay on a recall program after active treatment. Naturally, we will make every effort to keep you informed of the treatment necessary for you. Your involvement and understanding are very important in the long-term success of your periodontal therapy.

Periodontal and implant treatment involves complex procedures and during the course of treatment unusual and unanticipated problems can arise. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using medication has certain risks. During periodontal treatment, possible complications including bleeding, prolonged numbness, and sensitive and/or loose teeth. I understand that I can ask for a complete listing of any possible complications.

All professional services are charged to the patient. Insurance forms will be completed to expedite carrier payment. I accept responsibility for payment regardless of insurance coverage. In the event payments are not received by agreed upon dates, I understand that 1 1/2 % monthly finance charge (18% APR) may be added to my account. I agree to pay collection and legal expenses if the account becomes delinquent. I have received the Notice of Privacy Practices in accordance with the Federal requirements of HIPAA.

_____ _____

Signature **Date**