WELCOME TO PERIO4U

We are pleased to welcome you to our practice. Please take a few minutes to fill out the forms as completely as you can. If you have any questions, we will be glad to help you. This information is confidential and will not be released without your consent. We look forward to working with you in maintaining your dental health.

Patient Information

Last Name _____ First Name_____ Middle N. ___Soc. Sec. # ____ /____ /____
Sex: ☐M ☐F Age____ Birth date ___ /___ /___ ☐Single ☐Married Occupation_____
Address_____City_____ State _____ Zip _____
Phone #**:** Home _____ Work _____ Mobile_____ E-mail_____
What are the best ways to reach you? ☐Text ☐ Cell phone ☐ Call home ☐Email ☐Mail
A VALID PHOTO ID AND INSURANCE CARD IS REQUIRED WITH SUBMISSION OF THIS FORM
If patient is a MINOR who is legally responsible? _____
Name of your general dentist_____
Whom may we thank for referring you? _____
Who should be notified in case of emergency?
1) _____ Relationship _____ Phone #_____

Insurance Information

Person responsible for the account _____
Relationship to the patient _____ Birth date ___ /___ /___ Soc. Sec. # ____ /____ /____
Address (if different) _____ City_____ State _____ Zip _____
Employer of person responsible for account _____ Occupation _____
Business address _____Business phone _____
Insurance company _____ Group # _____ Subscriber # _____
Names of other dependents covered under the plan _____

Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No
Subscriber name _____ Relationship to the patient _____ Birth date _____
Address (if different) _____ City_____ State _____ Zip _____
Subscriber employed by_____ Occupation_____
Business address _____ Business phone _____
Insurance company _____ Group # _____ Subscriber # _____
Names of other dependents covered under the plan _____

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dentist to share information regarding my health and treatment with health care providers involved with my care.

I understand that I am financially responsible for all charges whether paid by said insurance or not. I understand that any broken appointments without **5 business day notice** will be subject to a $60 charge per every 30 minutes missed.

Name _____ Signature_____ Date___ /___ /___

Payment is due in full at time of treatment unless prior arrangements have been approved.