Annapolis Periodontics

practice limited to periodontics and implant dentistry

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PATIENT NAME ____
(first) (middle) (last)

Preferred Name or Nickname____
Birth Date ____________________ Sex M F Marital Status S M D
Address ____ Apt# __________
City _____________________________ State ___________ Zip Code __________________
Home Phone (____) _______________ Work Phone (____) _________________________
Cell or other(____)____________SS# _______________________________
E-mail Address ____
Employer's Name_______________________________Occupation___________________________
Employer's Address ________________________________ Full Time Student Y N Grade_______
Has any member of your family ever been treated in our office? Y or N
Whom may we thank for referring you to our office?_______________________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT (if different from above)

Relationship to Patient ( ) Spouse ( ) Parent/Guardian ( ) Other _______________________
Name _______________________________________ Birth Date _______________Sex M F
Does this person reside in the same household? Y or N
Address ____ Apt# ___________
City _____________________________ State ___________ Zip Code _________________
Home Phone (____) ____________________ Work Phone (____) __________________
Cell or Other (____) ____________________ SS# ________________________________

IS THE PATIENT COVERED BY DENTAL INSURANCE? ( ) Yes ( ) No

If no, skip to next page

Insurance Company Name ____________________________Group#_________________________
Claims mailing address____
Phone (____) ____________________________
Policyholder's Name ___________________________________Birth Date _____________ Sex M F
Policyholder's SS#____
Policyholder's ID# ____
Policyholder's Address (if different from patient) ____
City __________________________ State _____________Zip Code _______________
Employer's Name ____
Employer's Address ____
Relationship to Patient ( ) Self ( ) Spouse ( ) Parent/Guardian

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DOES PATIENT HAVE SECONDARY DENTAL INSURANCE? ( ) Yes ( ) No
Insurance Company Name ________________________Group# ____________________________
Claims mailing address ____
Phone (____) ____________________________
Policyholder's Name __________________________________Birth Date _____________ Sex M F
Policyholder's SS#___________________________________
Policyholder's Address (if different from patient)

____
City _________________________ State _____________Zip Code _______________
Employer's Name

____
Employer's Address

____
Relationship to Patient ( ) Self ( ) Spouse ( ) Parent/Guardian

PERSON TO CONTACT IN CASE OF EMERGENCY
(Outside of immediate family/household)
Name ____
Address____
City _________________________State __________ Zip Code ___________________________
Home Phone (____) __________________ Cell or Other (____) _________________________

TREATMENT AUTHORIZATION

I hereby authorize Annapolis Periodontics, Drs. Odell, Miele and Bly to administer such medications and perform such diagnostic, therapeutic and surgical procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are true to the best of my knowledge. I also understand it is very important to report any changes in my medical or dental status to my provider at the earliest possible time, and I agree to do so.

Signature ____ Date ____________________

PAYMENT AUTHORIZATION

I hereby authorize payment directly to Annapolis Periodontics, Drs. Odell, Miele and Bly of the group insurance benefits otherwise payable to me. Due to the constantly changing insurance rules and regulations, benefits and deductibles, the Dental Office is only able to approximate your out-of-pocket expenses for dental treatment. Your dental insurance benefits are based upon a contract between you or your employer and the insurance company, not our office. If your insurance pays more than expected you will be credited the difference. I understand that if payments are not received by the agreed upon dates, a finance charge may be added to my account after 90 days of the date of service in addition to any collection or attorney fees. I authorize the use of my social security number to file my dental claim and understand that if one is not provided to the office, payment in full will be collected at each visit. Payment is expected at time of service and cancellation or failure to keep a scheduled appointment without a 48 hour notice may result in a charge for the time reserved for you. It is important for you to understand that you are personally responsible for all charges that you or a dependent may incur in this office. I understand and accept final responsibility for all costs incurred.

Signature ____ Date ____________________