## ACCOUNT INFORMATION AND INSURANCE

**PATIENT INFORMATION**

______________________________________________
Last Name First Name Middle

___/_____/____________________________________
Date of Birth SSN: Sex M/F

______________________________________________
Mailing/Billing Address City State Zip

______________________________________________
Employer Employer Address/City/State/Zip Employer Phone #

______________________________________/_____/______
Spouse's Full Name Date of Birth

______________________________________________
Spouse's Employer Employer Address/City/State/Zip Employer Phone #

______________________________________________
***Person to contact in case of emergency:*** Phone #

## INSURANCE INFORMATION

**Primary**/Employee

______________________________________________
Employee Name/Birthdate Group Number and SSN

______________________________________________
Insurance Company Name Address Phone #

**Secondary**/Spouse

______________________________________________
Spouse Name /Birthdate Group Number and SSN

______________________________________________
Insurance Company Name Address Phone #

## RESPONSIBLE PARTY FOR PAYMENT OF SERVICES IF OTHER THAN THE PATIENT

______________________________________________
Name Relationship to Patient SSN:

______________________________________________
Mailing Address City State Zip Phone #

______________________________________________
Employer City State Zip Phone #

I hereby authorize my insurance benefits to be paid directly to the periodontist. I authorize the release of such information as required for insurance reimbursement. I understand that I am financially responsible for any balance due and that payment from my insurance carrier is subject to my deductible, yearly maximum and eligibility at the time the services are rendered.

______________________________________________
Date Signature of Patient, Parent or Responsible Party