PATIENT INFORMATION

LAST NAME_____FIRST NAME_____

NICKNAME _____ DOB:_____ SSN:_____

CELL# (___)_____ALTERNATE# (___)_____ EMAIL:_____

STREET ADDRESS:_____ZIP:_____

EMERGENCY CONTACT: NAME_____ PHONE NUMBER (___)_____

DENTAL BENEFIT PLAN ("Insurance")

DENTAL BENEFIT PLAN COMPANY_____

ID#_____ GROUP#_____

PRIMARY POLICY HOLDER:

LAST NAME_____ FIRST NAME_____INITIAL_____

EMPLOYER_____SSN#_____DOB_____

RELATIONSHIP TO INSURED_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

ASSIGNMENT AND RELEASE

This signature on file is my authorization for the release of information necessary to process my claim(s). I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that I am responsible for all charges whether or not paid by the Insurance/Benefit company. I understand that payment is due on the day that services are rendered. I authorize the use of this signature on all insurance/benefit submissions.

I hereby authorize Southern Colorado Periodontics to administer medications and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I provided on this form is correct to the best of my knowledge.

SIGNATURE_____PRINT NAME_____DATE_____