PATIENT REGISTRATION

TODAY'S DATE___________________________ **Home Phone #**______________________________

Patient ____

Last name *first name* *initial* *circle or add: (*Mr, Ms, Mrs., Dr., Hon.)

I prefer to be called________________________________ **Male**____**Female**_____

Birthdate___/___/___ **Age**____**SS#**___________________________only requested if not paying as you go.

Full Address____________________________________**City**_____________**State**_______**Zipcode**_______

e-mail address___________________________**CELL PHONE#**___________________________________

married___**single**___**divorced**__**widowed**__**separated**__**pager#**_____________________________________

Employer name&address__________________________________**office phone#**____________________

Position____**office fax#**____________________________

Whom may we thank for referring you?____

General Dentist name_______________________________________**phone #**_______________________

Other Family members seen by us____

Spouse's name_____________________________________**Employer**______________________________

Spouse's daytime #___________________**Occupation**____

Person Responsible for account : (only if patient a minor or disabled)

Name____**Daytime #**_____________________________

Street/City/State/Zip____

Employer/address___________________________________**Soc Sec #**_____________________________

Birthdate________________**Relationship to patient**____

I agree to be financially responsible for the above patient__________________________________

Payment for services rendered are due and payable at the time of treatment unless arrangements have been made in advance. After 90 days amounts due will accrue interest of 18% annual percentage rate. We accept American Express, Visa, Mastercard, and Discover as payment. When payment arrangements are made we require monthly payments. Procedures for implant therapy and cosmetics are only payable in full at time of service. If unable to use a reserved appointment, we request notice of *2* full business days. We reserve the right to charge broken appointment fees, patients are notified beforehand when possible. Without 48 hour notice the fee is a minimum of $70.00. We maintain a 24 hour answering service.

DENTAL INSURANCE: We do NOT have a contract with any insurance carrier. Insurance policies are contracts between the patient/employer and the carrier only. Amounts due are the full responsibility of the patient/responsible guardian. We offer insurance billing help for treatment amounts of $500.00 and above. To fill out forms on behalf of the patient, the following information fields must be completed. 18% interest will be applied on amounts that are pending payment by insurance after 90 days. We recommend pre-treatment estimates. Your estimated patient share of the fees is required at the time of service unless you have made arrangements before treatment. If you choose to reserve an appointment before the pretreatment estimate is processed the patient is responsible for any financial risk and a 50% estimated downpayment is requested at the time of treatment.

Primary Carrier Name and Address:____

Patent relationship to employee:______________**Subscriber birthdate:**________________**Subscriber sex: M F**

Subscriber name and address:____

Subcriber ID #______________________________________**Policy #** ___________________________________

Subscriber's Employer____

Are you covered by a Secondary Plan? Yes or NO if so:

Secondary Carrier Name and Address:____

Patient relationship to employee:______________**Subscriber birthdate:**_______________**Subscriber sex: M F**

Subscriber name and address:____

Subcriber ID#______________________________________**Policy #**___________________________________

Subscriber's Employer____

I have been informed of the treatment plan and fees. I agree to be responsible for all fee for services and materials not paid by my dental benefit plan. To the extent permitted by law I consent to your use of my protected health information to carry out payment activities in connection with this:

____date_____________________

I hereby authorize payment of the benefits otherwise payable to me directly to Buckhead Periodontics, P.C.:

____date_____________________