221 North Hamilton Road
Gahanna, Ohio 43230
FRED ALGER, D.D.S., M.S., LLC Telephone: (614) 478-7757
Practice Limited to Periodontics and Dental Implants

PATIENT ACCOUNT INFORMATION

Patient's Full Name _____ Nickname _____

Address _____ City _____ Zip _____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Email Address _____ Social Security #_____ Date of Birth _____ Age _____

Marital Status _____ If Married, Spouse's Name _____

If a Minor, Name of Parent(s) or Guardian(s) _____ Soc. Sec. #_____

Patient's Employer _____

Patient's Physician's Name _____ Physician's Phone (____)_____

Physician's Address _____ City _____ Zip _____

In Case of Emergency, Contact (Other Than Spouse) _____ Phone (____) _____

Dentist's Name _____ Who Referred You to Dr. Alger? _____

Primary <u>Dental</u> Insurance Co. _____ Phone (____) _____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient_____ Insured's Birth Date _____ S.S. # _____

Secondary <u>Dental</u> Insurance Co. _____ Phone (____) _____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient_____ Insured's Birth Date _____ S.S. # _____

I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I understand that charges due by the patient not paid within 30 days of billing may be subject to interest or late payment fees, unless financial arrangements are approved in advance. I understand that there will be a return check fee of $30.00. We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice.

Signature _____ Date _____