Creating Healthy Smiles
Dr. Fred Alger
PERIODONTICS & DENTAL IMPLANTS

Practice Limited to Periodontics and Dental Implants

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PATIENT ACCOUNT INFORMATION

Patient's Full Name _____ Nickname _____

Address _____ City _____ Zip _____

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

Email Address _____ Soc. Sec. # _____ Date of Birth _____ Age ____

Martial 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 Dental Insurance Co. _____ Phone (____)_____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____ Subscriber ID # _____

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

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

Secondary Dental Insurance Co. _____ Phone (___)_____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____ Subscriber ID # _____

Name of Insured Subscriber (Who's name is the 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 _____