



Practice Limited to Periodontics and Dental Implants

221 North Hamilton Road
Gahanna, Ohio 43230
(614) 478-7757
www.drfredalger.com

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 _____
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 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 _____