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 _____ 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 Dental 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 Dental 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 _____