Practice Limited to Periodontics and Dental Implants

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Gahanna, Ohio 43230
(614) 478-7757
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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 ________________

Pharmacy ________________ Pharmacy Address ________________ Pharmacy Phone ________________

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 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 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 are 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 $45.00. We reserve the right to charge for appointments canceled or broken without 48 hours advanced notice.

Signature ________________ Date ________________