Coastal Periodontics & Implant Dentistry, P.C.

Chart#_____

☐Mr.☐Mrs.☐Ms.☐Dr._____
Last First M.I.

Sex: ☐Male ☐Female Birth Date_____SS#_____Email_____

Street_____City_____St_____Zip_____

Home Tel.(____)_____Cell (____)_____ Have you been a patient of our practice? ☐Yes ☐No

Referred By: _____Has a family member ever been a patient of our practice? ☐Yes ☐No

Employer _____Tel._____Ext._____

In case of emergency, please contact _____Tel. _____Relation _____

Who Will be Responsible for Your Account:

☐Self (If self, skip this section) ☐Spouse ☐ Father ☐Mother ☐Other _____

Name_____SS#_____ Birth Date_____

Street _____City_____ST_____ Zip_____

Tel._____Cell_____Email_____

Employer_____Tel._____Ext._____

Spouse or Other Guarantor Information

Name _____Relation _____SS#_____ Birth Date_____

Street _____City_____ST_____ Zip_____

Tel._____Cell_____Email_____

Employer_____Tel._____Ext._____

Do you have Dental Insurance? Y N ***Do you have a secondary Dental Insurance? Y N***

Payment Options For Our Patients

As a courtesy to our patients, we will file all dental insurance claims. Most insurance policies do not cover 100% of the treatment fee. Most policies have deductibles and estimated remaining percentages due at the time of services rendered. Unless arrangements are made in advance, all payments are due at this time. To avoid misunderstandings with your account, if the insurance has not paid in 90 days, the balance becomes your responsibility. Due to volume of practice, we will send one final statement after the insurance sends payment on claim or 90 days. The fee for handling a non-sufficient funds (NSF) check is $20. Any delinquent accounts are subject to collection fee of 33 1/3% and attorney fees.

Insurance Authorization and Assignment

I hereby authorize Coastal Periodontics to furnish information to insurance carriers concerning my treatment and I do hereby assign to the dentist(s) all payments for dental services rendered to myself or my dependent. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Signature of responsible party _____Date_____