VIRUET PERIODONTICS
IMPLANTS - LASER THERAPY

PATIENT INFORMATION

Patient Name: _____Date:_____
Last First MI
How do you prefer to be addressed by the doctor and staff?_____
Please circle one: Mr. Mrs. Ms. Miss. Dr. Rev. Other:_____
Date of Birth_____
Address: _____ Home phone:_____
_____ Work phone: _____Ext._____
E-mail _____ Mobile phone: _____
Additional Address: _____
Email _____
Marital Status: Married _____ Single _____ Divorced _____ Widowed _____
In case of emergency please call _____ Phone # _____
Whom can we thank for referring you to our practice? _____
Name of general dentist: _____
Primary dental complaint or reason for referral: _____

EMPLOYMENT INFORMATION

Occupation/Former Occupation:_____
Employer Name/Former Employer Name: (please no abbreviations)_____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

DENTAL INSURANCE INFORMATION

Our insurance coordinator is pleased to assist you in filing insurance claims. Please present your dental and medical insurance cards, driver's license, and full completion of this form. The requested information helps us better serve you in filing dental insurance claims and maximizing insurance benefits.

PRIMARY **Dental Insurance Company _____ Phone # _____**
Claims address _____
Group # _____ Policy or Identification # _____
Name of policy holder _____ Relationship to patient_____
Policy holder birth date ____/____/_____ Policy holder social security # _____
Policy holder's employer _____
Employer's phone #_____ Employer's address _____

Please note that the adult accompanying a minor (under the age of 18) is financially responsible for that patient, no exceptions.

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

I understand that payment for professional services is the sole responsibility of the patient (parent/guardian if under 18) and is due as services are rendered. We do not render services on the basis that insurance companies will pay our fees, but we will be happy to assist you in filing claims for insurance reimbursement.

I understand that my above insurance coverage is a contractual arrangement between myself and my insurance company and I accept full financial responsibility for all services rendered, regardless of changes in coverage, termination, and/or cancellation of benefits.

_____ _____ _____
Date **Signature of Patient or Parent (if under 18)** **Relationship to Patient**