NORTH HILLS PERIODONTICS, LLC

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REGISTRATION AND TREATMENT FORM

Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____ May we call your work number? Y_____ N _____

Employer_____

Email _____Social Security # _____-_____-_____

Date of Birth _____/_____/_____ Single _____ Married ____ Widowed ____ Separated ____ Divorced____

Emergency Contact_____ Phone ( )_____

Name of Dentist_____

DENTAL INSURANCE INFORMATION

Insured _____ Relationship to Insured _____

Social Security/ID # _____Date of Birth _____/_____/_____

Insurance Company _____ Phone ( )_____

Group # _____Employer _____

SECONDARY DENTAL INSURANCE

Insured _____ Relationship to Insured _____

Social Security/ID # _____ Date of Birth _____/_____/_____

Insurance Company _____ Phone ( )_____

Group # _____Employer _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges and my balance regardless of insurance. I understand that I may incur a 12% APR if my account is not paid in full at time of service or payment plan is delinquent.

Signature _____ Date_____