

# WEST VALLEY PERIODONTICS

## NEW PATIENT INFORMATION SHEET

NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_  
                    LAST                    FIRST                    MIDDLE  
ADDRESS: \_\_\_\_\_ APT NO.: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ D.L. NUMBER: \_\_\_\_\_ EXP: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
SPOUSE NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? \_\_\_\_\_  
GENERAL DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### **PRIMARY DENTAL INSURANCE:**

INSURANCE NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_  
CLAIMS ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME OF INSURED PERSON: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
INSURED SOCIAL SECURITY: \_\_\_\_\_ INSURED DATE OF BIRTH: \_\_\_\_\_

### **SECONDARY INSURANCE:**

INSURANCE NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ID#: \_\_\_\_\_  
CLAIMS ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
NAME OF INSURED PERSON: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
INSURED SOCIAL SECURITY: \_\_\_\_\_ INSURED DATE OF BIRTH: \_\_\_\_\_

## CONSENT FOR SERVICES

1. I UNDERSTAND THAT PAYMENT FOR DENTAL SERVICES PROVIDED BY THIS OFFICE FOR EITHER ME OR MY DEPENDENT, IS MY RESPONSIBILITY AND DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.
2. PATIENTS WITH DENTAL INSURANCE: I UNDERSTAND THAT ALL DENTAL SERVICES PROVIDED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR ENTIRE COST OF TREATMENT. AS A COURTESY, THIS OFFICE WILL ASSIST ME WITH PREPARING MY INSURANCE FORMS AND WILL MAKE EVERY EFFORT IN OBTAINING REIMBURSEMENT FROM MY INSURANCE COMPANY. I UNDERSTAND ANY DEDUCTIBLE AND ESTIMATED CO-PAYMENTS ARE DUE IN FULL AT THE TIME OF SERVICE.
3. I give my consent to allow West Valley Periodontics to receive payment directly from my insurance company, but understand that this office cannot render services based on the assumption that an insurance company will pay. I agree to notify the office immediately if there are any changes regarding my insurance coverage.
4. As a condition of my treatment by this office, any financial arrangements must be made in ADVANCE, prior to the actual treatment. I understand the practice depends upon financial reimbursement from its patients.
5. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless a previously written and signed financial arrangement exists and is being satisfied. I further agree to pay all financial charges, collection costs, 50% of attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding on my account.
6. I agree to pay the fee of \$35 if I fail to give at LEAST a 24 hour notice upon canceling any appointment.
7. I agree to pay the fee of \$35 for any returned check.
8. All emergency services, or any dental services performed without previous financial arrangements, must be paid for in full at the time of service.
9. I hereby authorize West Valley Periodontics to release any of my information that may be required to my dental insurance company, third party payer and/or health practitioners.
10. I grant my permission to West Valley Periodontics or your assignee, to telephone me at home or at my work to discuss matters related to this form.
11. I have read the above conditions of treatment and agree to their content.

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_