Patient Registration Form

The following information is confidential and for our records only.

Welcome to Periodontal Associates of Winter Park. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. For us to serve you better, please take several minutes to complete this information as thoroughly as possible.

Name: Mr., Mrs., Ms., Miss, Dr. ____ Age________

Date of Birth____________________ Social Security #: _______________________

Home Address: _________________________________ City_________________________ State_____ Zip___________

Phone# _________________________ Work# __________________________ Cell#_____________________________

Email Address: _______________________________@_______________________

Employer: ____

Work Address: ____ City______________ State______ Zip___________

Who should we contact incase of emergency? _________________________________ Phone# ____________________

What is your chief dental complaint? : ____

Who may we thank for referring you to our office?:____

Dental Insurance Information

Relation to Patient: Self/Spouse/Child/Other Insured Name: ____

Insured Date of Birth: __________________ Insured Employer: ____

Insured Social Security #: _______________ ID#:_________________________ Group #:__________________________

Group Plan Name: ________________________________ Carrier Name: _______________________________________

Carrier Phone #: ____________________ Claims Address: ____

Authorization for treatment: This is to certify that I, undersigned patient or guardian consent to all dental procedures agreed to between myself and the periodontist at Periodontal Associates of Winter Park, including the use of local inhalation, sedative or general anesthesia as indicated, and I will assume complete responsibilities for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Periodontal Associates of Winter Park, is at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

Patient (Guardian's) Signature:____ Date: _______________