

**PATIENT DEMOGRAPHIC INFORMATION**

Mr. Mrs. Miss Ms. Dr. \_\_\_\_\_

I wish to be called at: home/ work, other \_\_\_\_\_ Name of Spouse/Partner \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext.#: \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Your General Dentist \_\_\_\_\_

(If Different from Referral)

**DENTAL INSURANCE INFORMATION**

**Primary Insurance**

**Secondary Insurance**

Name of insured \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship of Patient \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Group Name \_\_\_\_\_

Group Name \_\_\_\_\_

\_\_\_\_\_ I am not covered by any Dental Insurance at this time

I, hereby authorize *Michael Edwards DDS, MSD*, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Michael D. Edwards DDS, MSD of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Michael D. Edwards DDS, MSD.

**Privacy of Information Policy:** I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

**Cancellation Policy:** There will be a substantial (1/3 normal fee) charge if a surgical treatment appointment is canceled with less than 3 working days notice. All other appointments require 1 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

**Payment:** There is a 5% discount for full payment by cash or check. Payment is due at the time of scheduling for surgical appointments, and you will be reimbursed with any insurance coverage.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

I give my permission for *Implant Dentistry and Periodontics*, to use close-up photographs for teaching or in any publication, either printed or electronic, including the Internet (website), published by *Implant Dentistry and Periodontics*, or any educational/dental professional publication where appropriate.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Guardian

\_\_\_\_\_  
Date of

\_\_\_\_\_  
Signature