RIVERPLACE
PERIODONTICS

Patient Information

Name: _____
Last First MI

☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

Address: _____
Street Apt# City State Zip

Birthdate: ____/____/____ Email: _____
MM DD YYYY

Telephone: (____)_____-_____ (____)_____-_____ (____)_____-_____
Home# Work#

Employer: _____ SS#: _____-_____-_____

Person Responsible For account:
☐ PATIENT ☐ GUARDIAN ☐ FATHER ☐ MOTHER

Insurance Information

Primary Insured

Last First MI

Street City State Zip

( ) ( ) ( )
Home # Work # Fax #

Email

/ / /
Birthdate MM/DD/YYYY Realtionship to patient

Employer Dental Insurance Company

SS# Subscriber# Group #

Secondary Insured

Last First MI

Street City State Zip

( ) ( ) ( )
Home # Work # Fax #

Email

/ / /
Birthdate MM/DD/YYYY Realtionship to patient

Employer Dental Insurance Company

SS# Subscriber# Group #

Emergency Contact

Name _____
Address _____
City/State/Zip _____
Phone # _____

Have any of your family members been to our office? Yes / No (circle one)
If yes, Who? _____
How did you hear about us? _____

Authorization

I hereby authorize payment directly to Riverplace Periodontics of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Riverplace Periodontics to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signature of Patient, Parent, or Gaurdian_____**Date:**_____