DENTAL IMPLANTS & PERIODONTAL CARE, PC
PATIENT CONFIDENTAL REGISTRATION

[ ] Mr. [ ] Mrs. [ ] Miss [ ] Dr. [ ] Child Today's Date_____

NAME_____/_____/_____ _____
Last First MI (Preferred name)

MAILING ADDRESS _____/_____/_____/_____
(Street or PO Box) (City) (St) (Zip)

HOME PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL ADDRESS _____

BIRTHDATE_____SOCIAL SECURITY _____

SEX: [ ] M [ ] F MARITAL STATUS _____

EMPLOYER_____WORK PHONE (____) _____

SPOUSE' NAME_____EMPLOYER_____

CELL PHONE (_____) _____ WORK PHONE_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

NAME OF PHYSICIAN_____NAME OF DENTIST_____

PHARMACY_____ PHARMACY PHONE_____

WHOM MAY WE THANK FOR THIS REFERRAL?_____

Have you or a family member been seen in this office? Yes_____ No_____ Who?_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY (not living with you):

NAME_____ADDRESS_____

_____/_____/_____PHONE (____)_____
(City) (St) (Zip)

INSURANCE INFORMATION

EMPLOYEE NAME_____ BIRTHDATE_____

EMPLOYER_____ NUMBER OF YEARS_____

NAME AND ADDRESS OF **DENTAL** INSURANCE CO_____/_____
Insurance Name (Street or PO Box)

_____/_____/_____ PHONE# (_____) _____

MEMBER ID _____ GROUP#_____

DENTAL IMPLANTS AND PERIODONTAL CARE, PC
Phillip L Parham, Jr., DMD, MS, FICD
AUTHORIZATION, RELEASE AND AGREEMENT TO PAY
FOR SERVICES RENDERED

*I authorize Dr. Parham to release any information including the diagnosis and the records of any treatment or examination to me during the period of such dental care to third party payers and/or other health practitioners._____

*I authorize and hereby request my insurance company to pay directly to Dr. Parham insurance benefits otherwise payable to me for services rendered when an outstanding balance remains due. Otherwise benefits will be reimbursed directly to me. In the event after requesting Insurance reimbursement be sent directly to the patient benefits are paid to our office, we will in turn reimburse patient on or around 1st or 15th of the month._____

*I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of ***all*** services on my behalf or on behalf of my dependants._____

*PLEASE NOTE: OUR OFFICE DOES NOT ENTER INTO AGREEMENTS WITH YOUR INSURANCE COMPANY AS ***WE ARE NOT*** A NETWORK PROVIDER. ***YOU*** ARE RESPONSIBLE FOR YOUR BILL._____

OFFICE FINANCIAL POLICY

We have adopted the following policy in order to minimize your dental cost. The initial visit, which includes examination, consultation and x-rays must be paid in full at the time of your service. We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, cash or personal checks. There will be a $35.00 service charge for ALL returned checks._____

In addition we also accept **CareCredit** this payment plan allows you to spread the payments over time. *CareCredit* has no application fee or annual fee. Ask our Receptionist or Financial Coordinator for an application. Please check your method of payment

Cash _____ Check _____ Credit Card _____ or CareCredit_____

Sixty percent (60%) of the estimated fee for treatment will be required on the day of service. We will submit your insurance to your ***primary*** insurance company as a courtesy to you. **Your outstanding balance is due regardless of the status of your insurance claim. Please understand the unpaid balance is your responsibility! All accounts must be PAID in full within (90) days from the date of service._____**

Please contact your insurance company or managed care information office to determine how you might be reimbursed or covered for a service provided in our office. You may also request our office to send a pre-treatment estimate to your insurance company. This will give you an estimate of what your insurance may pay.

We will send monthly statements that will reflect any payment received from your insurance company. Most insurance companies will respond within four to six weeks. We will help in getting your claim paid in a timely manner. **Again, regardless the status of your insurance claim, the balance is due within ninety (90) days from the date of service._____**

Please realize that failure to keep this account current may result in Dr. Parham being unable to provide additional dental services including dental emergencies. Additional services will need to be prepaid. In case of default of this account, you agree to pay all collection cost and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances for you or your dependants. If you have questions regarding your account, please contact our financial office at 706-278-5344. Many times a simple telephone call will resolve any misunderstandings._____

Payment for services is due in FULL at the time service is provided. In the event your account is delinquent and placed with a collection agency you are responsible for the collection fee of 30% of the account balance as liquidated damages, and if an attorney is hired to collect, after maturity, 15% of unpaid principal and interest owing on said account as attorney's fees.

We ask you to sign our Financial Policy and Authorization reflecting acknowledgement and understanding of these policies.

SIGNATURE_____DATE_____

YOU MUST BE EIGHTEEN (18) YEARS OF AGE OR OLDER TO SIGN THIS FORM