



# COMPTON AND WEIR

periodontics & implants

901-763-4700

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Alternate Phone/Pager: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Email: \_\_\_\_\_

Referring Dentist / Person : \_\_\_\_\_

Referring Dentist Phone: \_\_\_\_\_

General Dentist: \_\_\_\_\_

General Dentist Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Preferred Pharmacy Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_

## PATIENT EMPLOYMENT INFORMATION

Employed  Unemployed  Retired  Other: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

## RESPONSIBLE PARTY (only fill out if patient is under 18 years of age)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

## PRIMARY DENTAL INSURANCE INFORMATION

Policyholder Name: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

ID#: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE INFORMATION

Policyholder Name: \_\_\_\_\_

Policyholder Address: \_\_\_\_\_

\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone: \_\_\_\_\_

ID#: \_\_\_\_\_

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

Employer Name: \_\_\_\_\_

**Please present your insurance card to the receptionist**

**Certification:** I certify that the answers that I have given are correct and accurate, to the best of my knowledge

**Record Updates:** I understand that it is my responsibility to notify the office of any changes.

**Release:** I hereby authorize the release of information acquired during my examination treatment according to HIPAA regulation.

**Assignment:** I authorize insurance payments to go directly to the doctor.

**Financial Responsibility:** I understand that I am financially responsible for services not covered by insurance, and should my bill become delinquent, that I am responsible for billing fees, collection costs, attorney fees and court costs.

**Billing:** I understand that billing statements will be sent electronically via text &/or email.

**Medicare:** I understand that neither the doctor nor I can file Medicare claims for services performed in this office.

**No-Show and Late Cancellations:** I understand that no-show appointments and cancellations with less than 48 business hour notice are subject to a late cancellation fee.

**Signature:** \_\_\_\_\_

Date \_\_\_\_\_

(Parent or guardian to sign if patient is under 18 years of age)