

# NORTHEAST TEXAS PERIODONTAL SPECIALISTS

*Periodontics & Dental Implants*  
Diplomate of the American Board of Periodontology

## GENERAL QUESTIONNAIRE

Mr. Mrs. Miss Ms. Dr. \_\_\_\_\_  
Last First Middle Initial

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

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

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

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

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by \_\_\_\_\_ Your General Dentist \_\_\_\_\_  
(If Different from Referral)

Employer \_\_\_\_\_ E-Mail \_\_\_\_\_

**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 practices policy statement on privacy of patients healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Permission to release information to: \_\_\_\_\_

**Surgical Appointment Deposit:** Our office requires a **non-refundable deposit** to secure you exclusive surgical procedure appointment as follows:

- a. **Dental Implant Surgery: 20% of the total fee is due at the time the appointment is made.**
- b. **Periodontal Surgery: 20% of you estimated fee (after review of insurance benefit) is due at the time the appointment is made.**

**Missed Appointments:** This office requires notice of cancellation on surgery appointments 48 hours (two working days) prior to surgery. When your appointment is made, we have set aside that time exclusively for you. When a patient does not show up for the appointment or cancels at the last moment, other patients are deprived of that treatment time.

**Cancellations with less than 48 hours notice will result in a forfeiture of your 20% deposit.**

**Payment:** Payment is due at the time services are rendered.

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

\_\_\_\_\_  
Signature of Patient or Patients Legal Guardian

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