

NORTHEAST TEXAS PERIODONTAL SPECIALISTS

Periodontics & Dental Implants

GENERAL QUESTIONNAIRE

Mr. Mrs. Miss Ms. Dr. _____
Last First Middle Initial

I wish to be called at: home work other _____ E-Mail Address _____

Home Phone (____) _____ Work Phone (____) _____ Ext.# _____ Cell (____) _____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____ - _____ - _____

Emergency Contact Name _____ Phone _____

Referred by _____ Your General Dentist _____

Employer _____ E-Mail _____

Pharmacy Name _____ Location _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Primary Coverage: (Relationship to Patient) _____

Policy Holder _____ Date of Birth _____ Social Security or ID # _____ - _____ - _____

Employer Name _____ Employer Address _____ Employer Phone # _____

Insurance Company _____ Phone # _____ Group/Policy # _____

Secondary Coverage: (Relationship to Patient) _____

Policy Holder _____ Date of Birth _____ Social Security or ID # _____ - _____ - _____

Employer Name _____ Employer Address _____ Employer Phone # _____

Insurance Company _____ Phone # _____ Group/Policy # _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of treatment, regardless of insurance coverage.

Signature (Patient, or parent if Minor)

I hereby authorize payment of the dental benefits otherwise payable to me directly to Northeast Texas Periodontal Specialists.

Signed (Policy Holder)