EASTSIDE
PERIODONTICS | IMPLANTS

PATIENT INFORMATION

Date_____
Patient's Name_____ Nickname_____
Date of Birth_____ Social Security #_____
Name of Spouse_____ Spouse Social Security #_____
If a Child, Parent's Name_____
Home Address_____Apt. #_____
City_____ State_____ Zip Code_____
Telephone: Home(____)_____ Cell(____)_____ Business(____)_____ Ext._____
E-Mail Address_____
Please check where you want us to confirm your appointments: ☐ Home ☐ Cell ☐ Business ☐ E-Mail
Employed By_____ Position_____
Business Address_____ City_____ State_____ Zip_____
Spouse Employed By_____ Spouse Business Phone(____)_____
Whom may we thank for referring you?_____
Who is your general dentist at this time? _____
Nearest relative not living with you_____
Contact in case of emergency_____ Telephone # (___)_____
Person responsible for payment of account_____
(name,address, telephone if different from above)

DENTAL INSURANCE

Primary Dental Insurance
Your dental insurance is through (check one):
☐ your employer ☐ your spouse's employer ☐ other
Employee's Full Name:
_____
Employee's Date of Birth_____
Employee's Social Security #_____
Employer's Name_____
Insurance Name_____
Insurance Address_____
Policy #_____ Group #_____
Employer ID#_____ Union Local #_____
Insurance Co. Phone(___)_____

Secondary Insurance (if you have dual coverage)
Your dental insurance is through (check one):
☐ your employer ☐ your spouse's employer ☐ other
Employee's Full Name:
_____
Employee's Date of Birth_____
Employee's Social Security #_____
Employer's Name_____
Insurance Name_____
Insurance Address_____
Policy #_____ Group #_____
Employer ID#_____ Union Local #_____
Insurance Co. Phone(___)_____

I understand that I am responsible for all costs of dental treatment and accept that should collection proceedings be instituted, attorney fees, collection expenses, interests and court costs will be imposed. I hereby authorize the release of dental or medical records as necessary to assist in dental treatment and/or relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Eastside Periodontics & Implantology to submit claims for benefits and services rendered or to be rendered and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize and assign direct payment of the dental benefits for such services otherwise payable to me, directly to Dr. Benjamin Russell. This assignment shall remain in effect until evoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient/Parent's Signature_____
Reviewed By_____ Date_____