MPDG
MARIN PERIODONTICS
DENTAL GROUP

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Dental Implants ■ Periodontal Microsurgery ■ Cosmetic Periodontics ■ Supportive Perio Therapy ■ Oral Medicine ■ Reconstructive Periodontics

PATIENT INFORMATION

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

Occupation _____ Name of Spouse/Partner _____

Address _____ Apt. No. _____

City, State, Zip _____ _____ _____
CITY STATE ZIP

Cell # (___)_____ Home # (___)_____ Work # (___)_____

Email _____

May we contact you via e-mail? ❑ Yes ❑ No

Birthdate_____ Social Security #_____ Employer_____

Referred by_____ Your General Dentist_____
First Name - Last Name First Name - Last Name

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name_____

Address_____

City_____ State_____ Zip_____

Phone No._____ Social Security #_____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name_____

Address_____

City_____ State_____ Zip_____

Phone No._____ Relationship_____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Name of insured_____	Name of Insured_____
Relationship to Patient_____	Relationship to Patient_____
Insured's Birthdate_____	Insured's Birthdate_____
Soc. Sec. #_____	Soc. Sec.#_____
Employer_____	Employer_____
Insurance Co._____	Insurance Co._____
Address_____	Address_____
Phone #_____	Phone #_____
Group #_____	Group #_____

(Over)

CONSENT FOR TREATMENT

I authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I hereby authorize doctors and staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to **Marin Periodontics Dental Group** of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Marin Periodontics and Marin Periodontics Staff. I understand that payment is due at the time of service unless other arrangements have been made. We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment. If required, I also understand a check of my credit history may be made.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is cancelled with less than 3 business days notice. All other appointments require 2 full business days notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

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 Patient's Legal Guardian

_____

Date of Signature