PerioPartner, P.A.

Matthew M. Abramson, D.M.D., M.S. *Specialist in Periodontics*

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PATIENT DEMOGRAPHIC INFORMATION

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

I wish to be called at: home work cell E-mail Name of Spouse/Partner_____

Address _____Apt. No._____

City, State, Zip _____

Home Phone (___)_____Work Phone (___)_____Ext. #_____

Cell Phone (___)_____Email Address _____

Birthdate _____ Social Security # _____-_____-_____

Referred by _____ Your General Dentist_____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

_____ I am not covered by any Dental Insurance at this time

Primary Insurance	**Secondary Insurance**
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Insured's Birthdate _____	Insured's Birthdate _____
Subscriber I.D. _____	Subscriber I.D. _____
Insurance Co._____	Insurance Co._____
Ins. Co. Address _____	Ins. Co. Address _____
Insurance Phone # _____	Insurance Phone # _____
Group # _____	Group # _____

Cancellation policy: If you need to change your reserved appointment time, please provide us with three full business days advance notice. This permits another patient to take your reserved time. An overhead charge is made if inadequate notice is given.

I hereby authorize Dr. Abramson, or his staff to release any and all medical and dental information (including x-rays, panoramic x-rays or CBCT scans) 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; and to my referring dentist and other dentists or physicians who may be involved in my care. In addition, I hereby authorize insurance payment directly to PerioPartner, P.A. from dental benefits for the services rendered to me by either the doctor or the staff. I have been informed that this office will report my diagnosis, treatment and fees to my insurance 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 insurance carrier(s) to determine the actual dollar amounts of benefits for all services rendered. This office cannot guarantee or assure me what my coverage will be. This office may file a pre-determination for benefits, but it is my responsibility to confirm with my insurance company what my insurance benefits coverage will be.

I understand that I am ultimately responsible for the total cost of my treatment provided by PerioPartner, PA.

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