

PATIENT INFORMATION

FULL NAME: _____
ADDRESS: _____ CITY: _____ ST _____ ZIP _____
HOME PHONE: _____ WORK: _____ EXT: _____
CELL# _____ PAGER: _____ SEX M F MARITAL STATUS:
SOCIAL SECURITY # _____ DATE OF BIRTH: _____ AGE: _____
EMPLOYER: _____ NUMBER OF YRS. EMPLOYED: _____
SPOUSE/GUARDIAN: _____ SOCIAL SECURITY # _____
DATE OF BIRTH: _____ EMPLOYER: _____ WORK # _____
PRIMARY DENTAL INSURANCE (SELF): _____
SECONDARY DENTAL INSURANCE (SPOUSE): _____
REFERRED BY: _____ MEDICAL DOCTOR: _____

GOVTI GPEI 'NFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
PHONE# _____ RELATIONSHIP: _____

THE FOLLOWING INDIVIDUALS HAVE MY PERMISSION TO DISCUSS MY MEDICAL RECORDS.
FINANCIAL ACCOUNT AND MY DENTAL TREATMENT.

NAME _____ RELATIONSHIP _____ PHONE _____
NAME _____ RELATIONSHIP _____ PHONE _____

IF DENTAL INSURANCE APPLIES: I HEREBY AUTHORIZE DR. SAM ALBORZ TO RELEASE ANY INFORMATION AND FILE MY INSURANCE AND TO RECEIVE PAYMENT OF MY BENEFITS AS LONG AS I AM A PATIENT OF RECORD. ALTHOUGH THIS OFFICE FILES CLAIMS AS A SERVICE TO THE PATIENT, THE INSURANCE CONTRACT IS BETWEEN THE PATIENT AND THE INSURANCE COMPANY. AS WE HAVE NO CONTROL OVER THE INSURANCE COMPANY'S METHOD OR AMOUNT OF PAYMENT. ANY DIFFERENCE IS ENTIRELY THE RESPONSIBILITY OF THE PATIENT/RESPONSIBLE PARTY. TEETH ARE SOMETIMES FOUND TO BE NON-RESTORABLE DURING TREATMENT. PART OF THE DIAGNOSTIG/WORK -UP IS TO FIND THESE THINGS PRIOR TO TREATMENT. IF A TOOTH IS FOUND TO HAVE DAMANGE THAT IS NOT REPAIRABLE (DEEP FRACTURES FOR EXAMPLE) DURING"VTGCVO GP V0CP '**INCOMPLETE ROOT CANAL TREATMENT** FEE OF AT LEAST 50% WILL BE INCURRED PLUS EXAM AND RADIOGRAPHS.

METHOD OF PAYMENT:

WHICH OF THE FOLLOWING WILL YOU BE USING? (FEES MUST BE PAID IN FULL AT THE COMPLETION OF TREATMENT.) CASH CHECK VISA MC DISCOVER

IF I DO NOT PAY THE ENTIRE AMOUNT WITHIN 30 DAYS OF THE MONTHLY BILLING DATE, I GRANT PERMISSION FOR DR. ALBORZ TO RELEASE ANY INFORMATION TO THE COLLECTION AGENCY. A FINANCE CHARGE OF 2% PER MONTH, AN APR OF 8.25%, ON THE BALANCE THEN UNPAID AND OWED WILL BE ASSESSED EACH MONTH (IF ALLOWED BY LAW). IF MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR AN ATTORNEY FOR COLLECTIONS. I WILL PAY THE DOCTOR'S ATTORNEY FEES AND AN ADDED 40% FOR COLLECTION COSTS. IF A CHECK IS RETURNED DUE TO INSUFFICIENT FUNDS A FEE OF \$35 WILL BE ADDED TO THE PRINCIPAL ALONG WITH ALL INTERESTS (ALLOWED BY LAW). IN THE EVENT THIS ACCOUNT IS INVOLVED IN LITIGATION, I EXPRESSLY WAIVE ANY OBJECTION TO VENUE AND SET VENUE WILL BE IN KNOX COUNTY, TENNESSEE.

SIGNATURE< _____ DATE: _____

UPDATES: _____

WITNESS: _____ DATE: _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM