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 SECURTITY # _____

DATE OF BIRTH:_____EMPLOYER:_____ WORK #_____

PRIMARY DENTAL INSURANCE (SELF): _____

SECONDARY DENTAL INSURANCE (SPOUSE): _____

REFERRED BY:_____MEDICAL DOCTOR:_____

EMERGENCY INFORMATION

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 DIAGNOSTIC 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 TREATMENT, AN **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