Progressive Periodontics & Implant Dentistry
MARC E. GORDON D.M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Patient: _____ _____
Last First MI Preferred Name

How did you hear about our office? _____

Street Address _____City _____ State _____ Zip _____

Home Phone _____ Business Phone: _____ Cell: _____

Birth Date _____ Age_____ Sex: M/F Single-Married-Widowed-Separated-Divorced

Patient S.S#_____ E-Mail Address _____

Employed By: _____ Address_____

SPOUSE/PARENT INFORMATION:

Name: _____ Birth Date_____
Last First MI

Employed By: _____ Address_____

Business Phone# _____ Ext: _____

INSURANCE INFORMATION: Yes No

PLEASE BRING INSURANCE CARD AND PRESENT IT TO THE OFFICE STAFF ON ARRIVAL

Primary Dental Insurance Coverage:
Name of Insured: _____ Relationship to Patient: Self / Spouse / Dependent

S.S# of Insured: _____ Birth Date: _____

Name of Dental Insurance Co.: _____ Group #_____

Secondary Dental Insurance Coverage:

Name of Insured: _____ Relationship to patient: Self / Spouse / Dependent

S.S# of Insured: _____ Birth Date: _____

Name of Dental Insurance Co.: _____ Group #_____

Please complete second page

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FINANCIAL POLICY

Welcome to Dr. Gordon's office. We would like to take this opportunity to inform you of our office financial policies.

Insurance and Billing:
We will bill insurance claims to primary and secondary carriers as a courtesy to our patients. You are responsible for providing us with up-to-date insurance information. We accept payment from many participating insurance plans, but require that you pay your estimated co-pay at the time of service. You will be responsible for any additional deductibles, coinsurance, and non-covered services. If you do not have insurance, payment for services is expected at the time of service unless specific written arrangements have been arranged with our office. The office policy is that the parent requesting treatment for a minor child is responsible for all fees incurred. We cannot become involved in billing disputes in cases involving divorce or separation.

Insurance policies have become increasingly complex over the years and it has become impossible for our office to know each specific plan and their limitations. Your insurance policy is a contract between you and your insurance company. We will do our best to research your insurance benefits to give you an estimate of insurance coverage and maximize allowable benefits for therapy. However, it is ultimately your responsibility to know your insurance benefits. You will be billed in the event that your insurance plan does not pay in a timely manner or is unresponsive to our claims submission. All fees are ultimately your responsibility.

Charges/Fees:
Appointments are reserved per your request so that we can deliver the quality, prompt care you and all of our patients deserve. All missed appointments with the doctor or hygienist and those cancelled with less than 48-hour notice will be subjected to a $35.00 to $50.00 fee. Also, in the event that a check is returned to us by your bank for any reason, there will be a $30.00 service charge.

Finance charges of 1.5%/month (18%) will be charged for account delinquencies of 90 days or greater.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS SET FORTH IN THE ABOVE POLICY AND ACCEPT FULL FINANCIAL RESPONSIBILITY.

_____ _____
Patient Name- Please Print Date

_____ _____
Patient or Parent/Guardian Signature Relationship