Baltimore Periodontics
Lasers & Dental Implants www.baltimoreperio.com
6400 Baltimore National Pike Ste. 200B, Catonsville, Maryland 21228 Phone 410-744-6088 Fax 410-744-6141

PATIENT INFORMATION: Please print clearly & **Fill in ALL Fields**

NAME ____SEX____ HOME PHONE __________________________
FIRST MI LAST
ADDRESS_____________________________________ Apt _________WORK PHONE__________________________
CITY_____________________________STATE______ZIP__________ CELL PHONE__________________________
EMPLOYER_________________________________BIRTHDATE_____________SSN__________________________
EMAIL ADDRESS: ____
PHARMACY NAME ____ PHONE ___________________
IN CASE OF EMERGENCY, CONTACT____________________________________ PHONE____________________
RELATIONSHIP______________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _______________________________________

PRIMARY DENTAL INSURANCE- We do NOT submit to medical insurance
NAME OF INSURED (Policy Holder) IF DIFFERENT THAN PATIENT____________________________
RELATIONSHIP TO PATIENT___________________ DATE OF BIRTH: __________SSN___________________
INSURANCE CO.____ PHONE ____________________________
ADDRESS______________________________________CITY___________________STATE______
ZIP_______________ GROUP # __________________________________
EMPLOYER_____________________________ SUBSCRIBER ID #______________________

SECONDARY DENTAL INSURANCE- We do NOT submit to medical insurance
NAME OF INSURED (Policy Holder) IF DIFFERENT THAN PATIENT____________________________
RELATIONSHIP TO PATIENT___________________ DATE OF BIRTH: ___________SSN____________________
INSURANCE CO.____ PHONE ____________________________
ADDRESS______________________________________CITY___________________STATE______
ZIP_______________ GROUP # __________________________________
EMPLOYER_____________________________ SUBSCRIBER ID #______________________

APPOINTMENT POLICY: Once an appointment is made, please remember this time has been reserved for you. All reminder calls and communications are done as a courtesy and you are responsible for keeping appointments that you have made. A minimum charge of $75 will be made for failed or cancelled non-surgical appointments without prior notification of 2 business days. For scheduled surgical appointments that are failed or cancelled with less than 5 business days prior notice by phone, a fee of $450.00 or 10% whichever is greater, will be forfeited and not refunded.
INITIAL___________

Insurance – We do NOT submit to medical insurance.
It is our pleasure to assist you in maximizing your insurance benefits and, as a courtesy; we will file your **dental** claims for you. **We will estimate your deductible and the portion not covered by your insurance, and this amount is due and payable at the time of service.** As it is impossible for us to know the details of every insurance policy, our **estimate** may differ from the actual coverage, and your account will be adjusted accordingly when your claim is paid. Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance policy is a contract between you and the insurance company. **You are ultimately responsible for the fees on the account regardless of insurance coverage. Insurance is not a substitute for payment.** If your dental insurance pays more than expected, any courtesy extended will be reversed, to zero out your account.

PATIENT TREATMENT CONSENT
- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requesting office or doctor.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. A fee of $35 will be charged for any returned checks.

PATIENT/PARENT OR GUARDIAN SIGNATURE
____ DATE___________

Your signature indicates that you acknowledge that should your account become delinquent; you will assume all additional costs incurred to collect the balance. This includes but is not limited to collection costs, attorney fees, filing fees, etc.