General Patient Information
Yorktown Periodontics
Sayward E. Duggan, DDS, MS

The following information is confidential and is for our records only.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Patient Name: ______________________________

Sex: M / F SSN: ______________ Date of Birth: ______________

Address: ______________________________
(Street) (City) (State) (Zip)

Telephone: Home______________ Cell ______________Work______________

E-mail address: ______________________________

Employed by: ______________________________

Name of Spouse: ______________ Spouse's Employer: ______________

Physician's Name: ______________ Phone: ______________

Dentist's Name: ______________

Person to Notify in Case of Emergency: ______________ Phone: ______________

IF PATIENT IS A MINOR:
Person Responsible for This Account: ______________ Relationship to patient: ______________

(Note: We do not file Medicare or medical claims)

	Primary Dental Benefit Plan	**Secondary Dental Benefit Plan**
Name of Insurance Company		
Phone #		
Group or Employer Name		
Group or Policy Number		
Policy Holder's Name		
Policy Holder's ID#		
Policy Holder's DOB		
Relationship to Policy Holder - self, spouse, child		

Regarding Payment for Services: Payment for services is due on the day service is rendered.
Regarding Appointments: I understand that whenever I make an appointment with the office of Yorktown Periodontics, I am reserving time specifically for myself. I understand that the dental office will call to remind me of my appointment in advance. **If I need to cancel or reschedule my appointment, I agree to give at least 2 business days notice for non-surgical appointments, and 5 business days notice for surgical appointments. I understand that not giving proper notification will result in a charge for unused appointment time.** Consideration will be given for emergent situations.
Regarding Dental Benefit Plans: I authorize the release of any information to all my insurance carriers and the filing of any insurance on my behalf with direct assignment and payment to Yorktown Periodontics. I understand that my insurance policy is a contract between my insurance company and me. As a courtesy, this office will file insurance on my behalf. I understand that I am financially responsible to Yorktown Periodontics for payment of any charges not covered by insurance.

Regarding Account Balance: In the event of default of any payment due to Yorktown Periodontics, I agree to pay all costs of collections including reasonable attorney's fees. A collection fee of 33.3 % is added to all balances forwarded to our collection agency.
By signing below, I acknowledge that I understand and agree to the above statements.

Signature ______________________________ Date ______________