Professional Periodontics and Dental Implants

Ivan P. Streif, D.D.S.

Patient Registration

Patient Information

Name:(First)_____(Last)_____(MI)_____

Street Address:_____

City, State, Zip Code:_____

Phone: Home:_____ Work:_____ Cell:_____

Social Security #:_____ Birthdate:_____

Employer:_____ Occupation:_____

E-Mail Address:_____

Marital Status:_____ Spouse's Name:_____ Phone #:_____

Who Referred You To Our Office?_____

Primary Dental Insurance Information

Policy Holder: (First/Last Name)_____ Relationship To Patient:_____

SS # or ID #:_____ Birthdate:_____

Insurance Company:_____ Employer:_____

Insurance Company Address_____

Insurance Company Phone #: _____ Group Number:_____

Secondary Dental Insurance Information (If Applicable)

Policy Holder: (First/Last Name)_____ Relationship To Patient:_____

SS # or ID#:_____ Birthdate:_____

Insurance Company:_____ Employer:_____

Insurance Company Address_____

Insurance Company Phone #: _____ Group Number:_____

DENTAL INSURANCE IS A CONTRACT BETWEEN THE POLICY HOLDER AND THE INSURANCE COMPANY. AS A COURTESY TO YOU WE WILL SUBMIT INSURANCE CLAIMS ON YOUR BEHALF AND WE WILL ASSIST YOU IN THE COLLECTION OF LEGITAMATE CLAIMS. IN THE EVENT YOUR INSURANCE COMPANY IS SLOW TO PAY OR DISALLOWS THE CLAIM PAYMENT, THE AMOUNT OWED IS THE PATIENT'S RESPONSIBILITY. ALL BALANCES ON ACCOUNTS OVER 30 DAYS PAST DUE WILL BE SUBJECT TO A FINANCE CHARGE OF 1.5% PER MONTH. A FEE OF $50 MAY BE ASSESED FOR APPOINTMENTS CANCELLED WITH LESS THAN A 48 HOURS NOTICE.

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