HARRIS PERIODONTICS & IMPLANT DENTISTRY

PATIENT INFORMATION

The following information is used to establish a record in our practice. All information provided is treated as confidential per current Health Information Privacy Portability Act (HIPPA) guidelines. Thank you for choosing Harris Periodontics & Implant Dentistry.

DATE: _____

FIRST NAME _____ LAST NAME _____ MI _____

ADDRESS _____
CITY STATE ZIP

PREFERRED NAME _____ REFERRING DOCTOR _____

HOME # _____ CELL # _____ WORK # _____

MARITAL STATUS _____ DATE OF BIRTH _____ SSN _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE # _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE _____ GROUP# _____

INSURANCE CLAIM ADDRESS _____

POLICY HOLDER: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER SSN or ID#: _____ EMPLOYER: _____

SECONDARY DENTAL INSURANCE _____ GROUP# _____

INSURANCE CLAIM ADDRESS _____

POLICY HOLDER: _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER SSN or ID#: _____ EMPLOYER: _____

To the best of my knowledge, the above information is accurate. It is my responsibility to inform Harris Periodontics of any changes to my personal information, insurance information or medical information.

Signature of patient or parent/guardian _____