Patient Information Form
(please complete & return to receptionist)

Gregory D. Perkins
7430South Creek RD. #100
Sandy, Utah 84093

Phone: 801-255-4870
Fax: 801-255-4882
www.gregperkinsdds.com
Email:doctor@gregperkinsdds.com

Name: Last, First, Middle	☐ Male	☐ Female	Today's Date

ADDRESS: Street or PO Box	City	State	Zip

PHONE NUMBERS: Home:	Cell:
EMAIL ADDRESS:	

AGE	BIRTHDATE	BIRTH PLACE	Single Married Divorced / Separated	SOCIAL SECURITY NO.

OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	PHONE NUMBER

SPOUSE OR PARENT	BIRTH DATE	ADDRESS

RELATIONSHIP	SOCIAL SECURITY NO.

OCCUPATION	EMPLOYER	HOW LONG EMPLOYED	PHONE NUMBER

Insurance Information

INSURED PERSON'S FULL NAME	DATE OF BIRTH

SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT	WORK PHONE

INSURANCE COMPANY NAME	GROUP OR UNION NAME	GROUP, LOCAL NO. OR PLAN NO.

EMPLOYER'S NAME	FULL ADDRESS OF INSURANCE COMPANY

DO YOU HAVE OTHER DENTAL INSURANCE

Getting To Know You

1. Why did you select our office? ____________________
____
____

2. Who may we thank for referring you? ____________________

3. Is there another member of your family or relative a patient in our practice? ____________________

4. Emergency contact not living with you: ____________________
Relationship: ____________________
Phone: ____________________

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six(6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, or at my request, to my minor child or ward, by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered, or within five (5) days of billing if court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge I hereby agree to abide by the conditions outlined herein,

______________________________ ____________ ______________________________

Signature of Patient, parent or guardian | Date | Relationship to Patient