



WEST COBB PERIODONTICS AND IMPLANT DENTISTRY

PATIENT REGISTRATION

Patient: _____ DOB: _____

First

Middle

Last

Address: _____

Phone number: _____ Email address: _____

Employer Name: _____

Office number: _____ Position: _____

Whom may we thank for referring to you? _____

General Dentist Name: _____ Phone number: _____

Spouse's Name/DOB: _____

Spouse's phone number: _____ Employer Name: _____

Parent/Guardian of Patient if under 18: _____

Name and DOB

Parent/Guardian address if different from above: _____

DENTAL INSURANCE

Insurance Name and Claims Address: _____

Patient ID/SSN: _____ Group Number: _____

Subscriber's Name, DOB, Address: _____

Relationship to Subscriber: _____

We do not have a contract with any insurance carrier. Insurance policies are contracts between the patient/employer and the carrier only. Amounts due are full responsibility of the patient/guardian. We will file the claim to your insurance company as a courtesy. You must fill out all the necessary fields for us to file your claim correctly. All fees are due at the time of service and the insurance company will reimburse you directly based on their fee schedule. When scheduling surgeries, we do ask for a nonrefundable deposit to be able to hold longer appointments and secure a spot. In the event of a cancellation, we will need 48 hour notice prior to the appointment. Cancellations less than 48 hours will be charged a \$75 non-refundable fee. Treatment plans are valid for 6 months. By signing below, you agree to these terms.

Signature: _____ Date: _____