Creating Healthy Smiles

Dr. Fred Alger

PERIODONTICS & DENTAL IMPLANTS

Practice Limited to Periodontics and Dental Implants

221 North Hamilton Road
Gahanna, Ohio 43230
(614) 478-7757
www.drfredalger.com

PATIENT ACCOUNT INFORMATION

Patient's Full Name _____ Nickname _____

Address _____ City _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Email Address _____ Social Security # _____ Date of Birth _____ Age _____

Marital Status _____ If Married, Spouse's Name _____

If a Minor, Name of Parent(s) or Guardian(s) _____ Soc. Sec. # _____

Patient's Employer _____

Pharmacy _____ Pharmacy Address _____ Pharmacy Phone _____

Patient's Physician's Name _____ Physician's Phone (_____) _____

Physician's Address _____ City _____ Zip _____

In Case of Emergency, Contact (Other than Spouse) _____ Phone (_____) _____

Dentist's Name _____ Who Referred You to Dr. Alger? _____

Primary Dental Insurance Co. _____ Phone (_____) _____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____ Subscriber ID#_____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient _____ Insured's Birth Date _____ S.S.#_____

Secondary Dental Insurance Co. _____ Phone (_____) _____

Dental Insurance Address _____ City _____ Zip _____

Group (Employer) Name _____ Group # _____ Subscriber ID#_____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient _____ Insured's Birth Date _____ S.S.#_____

I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I understand that charges are due by the patient not paid within 30 days of billing may be subject to interest or late payment fees, unless financial arrangements are approved in advance. I understand that there will be a return check fee of $45.00. We reserve the right to charge for appointments canceled or broken without 48 hours advanced notice.

Signature _____ Date _____