Ralph W. Price, D.D.S.

Practice Limited to Periodontics • Implants

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr._____
Last First Middle Initial

I wish to be called at: home work cell email _____ Name of Spouse/Partner_____

Email Address _____ Cell Phone (___)_____

Address _____Apt. No. _____

City, State, Zip _____

Home Phone (____)_____Work Phone (___)_____Ext.#_____

Birthdate _____ Social Security # _____-_____-_____

Referred by _____Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of insured_____

Relationship to Patient_____

Insured's Birthdate _____

Soc. Sec. or ID# _____-_____-_____

Employer_____

Insurance Co. _____

Group # _____

Insurance Phone #_____

Secondary Insurance

Name of Insured_____

Relationship of Patient_____

Insured's Birthdate _____

Soc. Sec. #_____-_____-_____

Employer _____

Insurance Co. _____

Group # _____

Insurance Phone #_____

___I am not covered by any Dental Insurance at this time

I hereby authorize Ralph W Price, DDS, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Ralph W Price, DDS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Ralph W Price, DDS.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 5 working days notice. All other appointments require 2 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature