PERIODONTAL THERAPY CENTER
Excellence in Periodontal Surgery

Jeffrey A. Hameroff, D.D.S. Practice Limited to Periodontics

Last Name _____ First _____ M I _____ Date of Birth _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Cell Phone # _____

Drivers License # _____ Social Security # _____

Email: _____ Husband/Wife's Name _____

If Child, Parent's Name _____ Phone Number _____

Person to Contact in Case of Emergency _____ Phone # _____

Patient Employed By _____ Work Number _____

Business Address _____ City _____ State _____

INS Company _____ **INS** Address _____

Subscriber's Name _____ ID # _____ Group # _____

Date of Birth _____ Social Security: _____

Referring Dentist _____ Family Physician _____ Phone# _____

The following medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction, or a major periodontal procedure.

Yes	No	DO YOU HAVE:
		Heart Murmur/ Irregular Heartbeat
		Heart Disease/Attack / Surgery
		Daily Aspirin
		Blood Thinning Medication
		Lung Trouble / Shortness of Breath
		Smoker
		Rheumatic Fever
		High or Low Blood Pressure (Circle one)
		Thyroid Problems
		Cerebrovascular Disease (Stroke)
		Prosthetic Joint Surgery
		Jaundice or Liver Disease
		Convulsions/ Seizures /Epilepsy
		Anxiety
		Asthma / Bronchitis
		Vitamin E
		Glaucoma [ ]Right [ ]Left

Yes	No	DO YOU HAVE:
		Diabetes or Insulin Dependent
		Kidney Disease
		Swelling of Ankles
		Snoring / Sleep Apnea
		Tumor / Cancer
		Radiation / Chemotherapy

Yes	No	Are You Allergic To?
		Penicillin
		Aspirin
		Codeine
		Anesthetics - like Novocaine
		Other Drugs _____
		Are You Pregnant?
		Taking Birth Control Medication

Any Previous Surgery & Anesthesia History _____

List all current medications you are taking:

Medications	Dosage	Medications	Dosage

If you are under the care of a physician at this time, state the nature of your problem: _____

Is there anything about your physical condition which should be called to the Doctors' attention? _____

Medical Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____
Signature of Patient (or parent of minor) Date

_____ _____
Employee Signature Doctor's Signature

PAYMENT POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we will be glad to help you receive your maximum yearly allowance. In order to achieve these goals, we need your assistance in understanding our payment policy. Payment is due at the time services are rendered. We accept CASH, CHECKS, MASTERCARD, VISA and DISCOVER. In SPECIAL circumstances we may accept assignment as a partial payment from your insurance company. In the event my account becomes 60 days past due, I understand that a 1-1 ½ finance charge (18% APR) may be added to my account on a monthly basis. Returned checks will be subjected to a $25.00 fee. Older balances than 90 days are subject to collection. Actions will be taken accordingly.

THERE WILL BE A $ 50.00 CHARGE FOR ANY PROCEDURE CANCELLED OR FAILED TO SHOW WITHIN A 24 HOUR NOTICE. AND A $ 25.00 CHARGE FOR PROPHY APPOINTMENTS.

We will gladly discuss your proposed treatment plan and answer any questions related to your insurance. You must realize that:

1) Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
2) Our fees are within **USUAL, CUSTOMARY AND REASONABLE** by most insurance companies. This statement does not apply to companies who reimburse based on arbitrary "schedule" of fees, which bear no relationship to the current standard and cost of care in this area.
3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Periodontal Treatment may not be covered by insurance; therefore, it is our policy to have the ***insurance*** company ***reimburses*** the patient.

Our emphasis as a dental provider and relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help you.

MEDICARE DOES NOT HAVE DENTAL BENEFITS.

I authorize treatment of services and agree to pay all fees and charges for such treatment.

_____ _____

Signed Patient or Parent if Minor Date

RELEASE OF INFORMATION TO INSURANCE COMPANY:
I authorize Dr. Hameroff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to my insurance company and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signed Patient or Parent if Minor Date

AUTHORIZATION TO PAY BENEFITS TO DENTIST:
I authorize and request my insurance company to pay directly to Dr. Hameroff or dental group insurance benefits otherwise payable to me. I certify the services listed have been received.

_____ _____

Signed - Insured Person Date