Landmark Total Dentistry

Personal Information

Date:_____

First Name:_____Last Name:_____Middle Initial:_____

Preferred Name:_____ Address:_____

City, State, Zip: _____

Home Phone:_____Work Phone:_____ Cell Phone:_____

Email Address: _____

☐ Male ☐ Female

☐ Minor ☐ Single ☐ Married ☐ Domestic Partner

Birth Date:_____ Social Security #:_____

Employer:_____ Occupation:_____

Who may we thank for referring you to our office?_____

How do you prefer to be contacted? ☐ E-mail ☐ Phone ☐ Text

Emergency Contact: _____ Phone #: _____

Responsible Party

Who is responsible for the account? _____

Name:_____

Relationship to Patient: _____Birth Date:_____ Driver's License #:_____

Social Security #: _____ Email Address: _____

Address:_____

City, State, Zip: _____

Employer:_____Occupation:_____

Method of Payment ☐ Cash ☐ Check ☐ Credit Card

Primary Insurance Information

Name of Insured: _____ Relationship to Patient:_____

Insured's Birth Date:_____ Insured's Social Security #_____

Employer:_____Date Employed:_____Occupation:_____

Insurance Company:_____

Claims/Insurance Company Address: _____

City, State, Zip: _____

Group #:_____ Employee ID #:_____

Deductible:_____ Maximum Annual Benefit:_____Amount Used:_____

Secondary Insurance

Insurance Company:_____

Claims/Insurance Company Address: _____

City, State, Zip: _____

Group #:_____ Employee ID #:_____

Deductible:_____ Maximum Annual Benefit:_____Amount Used:_____

Consent:

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine; due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court fees. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Dr. Per T. Reiakvam. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this provider and its employees, agents, and assignees to contact me via Email, text messaging, and my cellular device.

Responsible Party's Signature: _____ Date: _____