Advanced Periodontics and Dental Implants, LLC
Andrew R. Samuel, D.M.D.
Practice Limited to Periodontics
NJ Specialty Permit No. 4005
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PATIENT INFORMATION

Name: _____ Date: _____

Marital status (circle): Single Married Widowed Divorced Other

Your occupation: _____

Your employer: _____

Spouse's name: _____

Spouse's occupation: _____

Spouse's employer: _____

Hobbies, special interests: _____

DO YOU HAVE DENTAL INSURANCE (circle): YES NO If yes, please continue. If no, you may skip the rest of this page.

DENTAL INSURANCE INFORMATION

Name of insured person: _____

Is insurance through an employer or self purchased (circle)?: Employer Self purchased

Dental insurance company name: _____

Claims mailing address: _____

Phone number: _____

Insured person's SS# or unique ID #: _____

Insured person's DOB: _____ / _____ / _____ Group #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of insured person: _____

Is insurance through an employer or self purchased (circle)?: Employer Self purchased

Dental insurance company name: _____

Claims mailing address: _____

Phone number: _____

Insured person's SS# or unique ID #: _____

Insured person's DOB: _____ / _____ / _____ Group #: _____

***** A NOTE ABOUT INSURANCE:** We will do everything possible to help you maximize your insurance benefits. However, dental insurance policies and plans vary greatly in the amount of coverage they provide. Please understand that **ALL PROFESSIONAL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT, NOT THE INSURANCE COMPANY.** We will be happy to submit any information necessary for the processing of your claims as a courtesy to you. *Thank you!*

ADVANCED PERIODONTICS AND DENTAL IMPLANTS, LLC

ANDREW R. SAMUEL, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

_____has received a copy of this office's Notice of Privacy Practices.
Please print name

_____ _____
Signature Date

This will serve as a notice that we have your signature on file to do the following:
1. PROCESS ALL INSURANCE CLAIMS;

2. ENSURE PAYMENT FOR SERVICES PROVIDED

3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS

4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

Patient Signature _____
Patient Full Name (printed) _____

Please complete this section to list methods we may use:

- ___OK to **mail** to my home address (address on file)
- ___OK to **email** me at _____
- ___OK to **text** me at _____
- ___OK to **telephone** me and/or leave a message regarding appointments/medical information at:
  Phone #_____
- ___Other person authorized to discuss my appointments/medical information:
  Name and Relationship_____

Other specific instructions or requests: _____
_____

FOR OFFICE USE ONLY

We attempted, in good faith, to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other: (please specify)_____

_____