Columbia Implants and Periodontics L.L.C

Practice Limited to Periodontics
Nabil E. Beaini, D.D.S.
Diplomate of the American Board of Periodontology
201 West Broadway Ste. 5A • Columbia, Missouri 65203

Please print and fill out form completely.

Patient's Full Name: ______________ (LAST) ______________ (FIRST) ______________ (MIDDLE) NickName: __________

Male ___ Female ___ Married ___ Single ___ Birthday: __________ Age: _____ SS#: __________ (SOCIAL SECURITY NUMBER)

Address: __________ (MAILING) __________ (CITY) __________ (STATE) __________ (ZIP CODE)

Home Phone: (____) __________ Cell Phone: (____) __________

Work Phone: (____) __________ Ext. _____ Email: __________

PREFERRED METHOD TO CONTACT YOU: ____ Home ____ Cell ____ Work

Patient's Employer: __________ Occupation: __________ How long Employed: _____

Employer's Address: __________ (STREET / PO BOX) __________ (CITY) __________ (STATE) __________ (ZIP CODE)

Spouse's Full Name: ______________ (LAST) ______________ (FIRST) ______________ (MIDDLE) Nickname: __________

Spouse's Birthdate: __________ SS#: __________ Occupation: __________ How long Employed: _____

Spouse's Employer: __________ Employer's Phone: (____) __________

Address: __________ (STREET / PO BOX) __________ (CITY) __________ (STATE) __________ (ZIP CODE)

Name of Emergency Contact: __________ Relationship: __________

Address: __________ (STREET / PO BOX) __________ (CITY) __________ (STATE) __________ (ZIP CODE) Phone: (____) __________

Referred By: __________

Present Dentist: __________ Physician: __________

Address: __________ (STREET / PO BOX) __________ (CITY) __________ (ZIP CODE) Address: __________ (STREET / PO BOX) __________ (CITY) __________ (ZIP CODE)

If patient is a minor:

Mother's/Father's Name: __________ SS# __________

Date of Birth: __________ Evening Phone: (____) __________

Address: __________ (STREET / PO BOX) __________ (CITY) __________ (STATE) __________ (ZIP CODE)

Dental Insurance Information

Subscriber's Name: __________ SS# __________ Birthday: __________

Insurance Co. __________ Employer: __________

Insurance Co. Phone # __________ Subscriber's I.D. # __________ Group #: __________

Do you have dual dental insurance coverage Yes _____ No _____

Subscriber's Name: __________ SS# __________ Birthday: __________

Insurance Co. __________ Employer: __________

Insurance Co. Phone # __________ Subscriber's I.D. # __________ Group #: __________

I certify the information I have provided on the front and back of the form is true 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. I consent to the taking of photographs and x-rays before, during and after treatment. I have read & understand the Notice of Privacy Practices (HIPAA) which is posted in the waiting room and/or available upon request.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized.

I agree to be responsible for payment of all services rendered on my behalf or my dependents in the event that my dental insurance carrier pays less than the actual bill for services. A finance charge may be imposed on my account if it has not been paid within 30 days of the time the treatment was completed. I agree to pay any collection fees, court cost or any other cost incurred.

______________________________ ______________

Signature of Patient (Parent/Guardian if patient is a Minor) **Date**

Please answer all questions on the reverse side of this form.