RICHARDSON ~ OVERSTREET ~ GLAZIER, LTD.

4909 GROVE AVENUE
RICHMOND, VIRGINIA 23226
TELEPHONE (804) 355-6593
FAX (804) 358-6394

EXCELLENCE IN PERIODONTICS

1230 ALVERSER DRIVE, SUITE 106
MIDLOTHIAN, VIRGINIA 23113
TELEPHONE (804) 794-7094
FAX (804) 794-9858

PT #: _____

PATIENT INFORMATION (CONFIDENTIAL)

NAME: _____ *DATE:* _____
FIRST **MI** **LAST**

ADDRESS: _____ *CITY:* _____ *STATE*: _____ *ZIP:*_____

SOC. SEC. #: _____ *BIRTHDATE:* _____ *HOME PHONE:* _____ *CELL PHONE:* _____

CHECK APPROPRIATE LINE: ___ *MINOR* ___ *SINGLE* ___*MARRIED* ___ *DIVORCED* ___ *WIDOWED* ___ *SEPARATED*

PATIENT'S EMPLOYER: _____ *WORK PHONE:*_____

BUSINESS ADDRESS: _____ *CITY:* _____ *STATE:*____ *ZIP:* _____

REFERRING DENTIST: _____

PERSON TO CONTACT IN EMERGENCY: _____ *PHONE #:*_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ *RELATIONSHIP TO PATIENT:* _____

ADDRESS: _____ *CITY:* _____ *STATE:* _____ *ZIP:*_____

HOME PHONE: _____ *CELL PHONE:* _____ *SOC SEC #:*_____

EMPLOYER: _____ *WORK PHONE:* _____

INSURANCE INFORMATION - PRIMARY INSURANCE ONLY – WE DO NOT FILE SECONDARY WE ARE OUT-OF-NETWORK PROVIDERS FOR ALL INSURANCE CARRIERS

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ *RELATIONSHIP TO PATIENT:* _____

DATE OF BIRTH: _____ *SOC. SEC. #:* _____

INSURANCE CO.: _____ *TEL. #:* _____ *GRP #:* _____ *POLICY ID #:*_____

INSURANCE COMPANY ADDRESS: _____ *CITY:* _____ *STATE:* _____ *ZIP:* _____

_____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR

PLEASE READ BACK SIDE OF FORM

FINANCIAL POLICY

WE ARE OUT-OF-NETWORK PROVIDERS FOR ALL INSURANCE CARRIERS

HOWEVER, IF YOU WOULD LIKE FOR US TO ASSIST YOU IN PROCESSING YOUR INSURANCE FORMS, WE NEED TO HAVE YOUR SIGNATURE ON FILE. THIS GIVES US THE AUTHORIZATION TO RELEASE TREATMENT INFORMATION TO YOUR INSURANCE CARRIER AND AUTHORIZES THEM TO PAY BENEFITS DIRECTLY TO US TO BE APPLIED AGAINST YOUR ACCOUNT.

BY HAVING YOUR SIGNATURE ON FILE, WE CAN USE OUR OWN COMPUTER-GENERATED FORMS, WHICH MAY NOT BE AVAILABLE FOR YOU TO SIGN WHEN YOUR TREATMENT IS PROVIDED.

YOUR SIGNATURE ON THIS FORM ALSO CONFIRMS THAT YOU HAVE BEEN OFFERED THE OPPORTUNITY TO READ THE PATIENT'S RIGHTS FORM, WHICH IS POSTED IN THE RECEPTION AREA.

_____ ***(patient initial)*** **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Richardson-Overstreet, Ltd. to release any information relating to my dental treatment.

_____ ***(patient initial)*** ANY PATIENT WHO FAILS TO SHOW UP FOR AN APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE MAY BE SUBJECT TO A BROKEN APPOINTMENT CHARGE OF $35.00.

_____ ***(patient initial)*** ***FOR VALUE RECEIVED*** *THE UNDERSIGNED HEREBY GUARANTEES PAYMENT TO RICHARDSON-OVERSTREET, LTD. OF ALL CHARGES INCURRED IN THE PAST AND TO BE INCURRED IN THE FUTURE BY THE UNDERSIGNED AND THE PATIENT NAMED ON THE REGISTRATION FORM, AND IF MY ACCOUNT HAS TO BE TURNED OVER TO AN ATTORNEY FOR COLLECTION, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING ATTORNEY'S FEES EQUAL TO 33.3% OF ALL SUMS DUE AND OWING. A TWENTY-FIVE DOLLAR ($25) FEE WILL BE CHARGED FOR ALL RETURNED CHECKES. I ALSO HEREBY ASSIGN UNTO RICHARDSON-OVERSTREET, LTD. ANY AND ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED UNDER ANY POLICY OF INSURANCE (HEALTH, DENTAL, AUTOMOBILE OR ANY OTHER).*

Patient Signature: _____

Parent/Guardian: _____

Date: _____

HOW WOULD YOU LIKE TO BE CONTACTED FOR FUTURE APPOINTMENTS?

____ ***Text*** ____***E-mail*** ____***Phone (H, W, C)***

_____ ***E-mail***