Sandhills Periodontics

PERIODONTICS, LASER, AND IMPLANT DENTISTRY

Sohee K. Park, DMD, MHS | Diplomate of the American Board of Periodontology

NEW PATIENT INFORMATION (*please print*)

(Dr., Mr., Mrs., Ms., Miss) Name ______________________________
Birth date ______________ Social Security # ______________ Married/ Single/ Divorced/ Widowed (circle one)
Guardian's name if patient is a minor ______________________________
Address ______________________________ ______________________________
(street) (city, state) (zip)
Employer______________________________Occupation______________________________
Primary telephone (________)______________Work/Other telephone (________)______________
Email Address: ______________________________
Emergency Contact Name: ______________________________ Emergency Telephone: ______________

ACCOUNT AND DENTAL INSURANCE INFORMATION

Person responsible for account (if different than patient):
Name______________________________
Address ______________________________ ______________________________
(street) (city, state) (zip)
Home telephone (_______)______________Work telephone (________)______________
Cell (_______)______________

PRIMARY INSURANCE COVERAGE – (Please inform the front desk if you have secondary insurance)

Insured's Name ______________________________
Birth date ______________
Relationship to patient: Self ______ Spouse_______ Child________
Other(describe)______________________________
Social Security or ID# ______________________________ Employer______________________________
Dental Insurance Company ______________________________Group Number______________________________
Address______________________________
Insurance Telephone (_________)______________________________

The undersigned consents to a periodontal examination and any additional diagnostic aids and/or services including surgical procedures that may be advised by Dr. Park. I understand that the payment responsibility for any periodontal services provided in this office for myself or my dependents is mine, and is due and payable by me at the time these services are rendered unless financial arrangements have been made. ***I further understand that all insurance claims not paid after 60 days are my responsibility.***

______________________________ Date______________________________
Patient or Responsible Party Signature

______________________________ Date______________________________
Witness