Synergy
PERIODONTICS & IMPLANTS
Lillie Pitman, DMD
Thanos Ntounis, DDS, MS

Patient Information

609 Jefferson Davis Hwy, Ste 101
Fredericksburg, VA 22401

Phone (540) 373-3066
Fax (540) 373-3747
Email info@periosynergy.com

periosynergy.com

Welcome to Our Office! *So that we may provide you with the best care, please fill out these forms completely.*

○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Male ○ Female Today's Date _____

Patient Name _____ Last _____ First _____ S.S. # _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age *(if Student)* _____ School _____

Occupation _____ Employer _____

If Married, please list Spouse's Name _____

Contact Information:

Home _____ Work _____ ext. # _____

Cell _____ Email _____

What is your preferred method of contact? ○ Home Ph. ○ Work Ph. ○ Cell Ph. ○ Email ○ Text

Is it okay for us to send you text reminders about your appointments? ○ Yes ○ No

Person financially responsible for this account:

(Parents or Guardians Name) _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

EMERGENCY CONTACT

Are other members of your family patient's at this office? ○ Yes ○ No

Please list their names _____

Person to contact in case of an emergency _____

Please list phone numbers where they may be reached _____

Address _____ City _____ State _____ Zip _____

PATIENT CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Parent/Guardian Name: (if patient is a minor) _____

Relationship to Patient: _____

Patient/Parent/Guardian Signature Date: _____

X _____

FINANCIAL COMMITMENT

I understand that payment is expected on the day of service and that any dental benefit reimbursements will be sent directly to me. Failure to notify the practice of an appointment cancellation with less than 2 business days notice may result in a pre-payment requirement or cancellation fee.

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and / or locating the undersigned, as may be necessary.

The undersigned understands that Dental Insurance claims may be filed by the provider, as a courtesy, if the under-signed promptly furnishes the provider with all correct insurance information.

In absence of prompt payment, the undersigned understands that dental, personal, and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

DENTAL INSURANCE INFORMATION

Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child

Subscriber Name _____ Sub.ID # _____ Sub.DOB _____

Insurance Company _____ Phone _____

Mail Dental Claims To (Address) _____

Employer _____ Group Name _____ Group # _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize this office to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or entity, this authorization also permits disclosure to them for purposes or utilization review or financial audit.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement ***

I, _____ have received a copy of this office's Notice of PrivacyPractices.
I also authorize this office to reveal my health information to my spouse/significant other/legal guardian (name) _____ if I am unable to be reached. This will include the authorization of this office to leave a message on my home's answering machine regarding my health information.

Parent/Guardian Name: (if patient is a minor) _____

Relationship to Patient: _____

Patient/Parent/Guardian Signature Date: _____

X _____

Thank you for filling out this form completely. It will enable us to render comprehensive care.
If you have any questions at any time, please feel free to ask us.
We are here to help you reach and maintain your maximum health potential.