Ann Hammi Blue, D.D.S., M.S., P.C

Blue Periodontics and Implants

Section I **Patient Information** **Date**_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Title_____ Name_____ I Prefer to be called_____

Address_____ City_____ State_____ Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is_____ ☐ AM ☐ PM on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth_____ Social Security Number_____ Driver License #_____

Email Address_____ Whom may we thank for referring you (name)_____

General Dentist Name_____ Address_____ Phone_____

Person to contact in case of emergency_____ Phone_____

In case of an emergency, which hospital would you prefer to be taken to if a choice is available? _____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name_____ Driver License #_____

Address_____

City_____ State_____ Zip_____ Phone (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III **Insurance Information**

Name of Insured_____ DOB_____ Relationship to Patient _____

SSN#_____ Name of Employer_____

Insurance Company_____ Group #_____ ID#_____

Ins Co Address_____ Phone_____

---DO YOU HAVE SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING---

Name of Insured_____ DOB_____ Relationship to Patient _____

SSN#_____ Name of Employer_____

Insurance Company_____ Group #_____ ID#_____

Ins Co Address_____ Phone_____

Patient acknowledgments:

I understand that I am responsible for any balance not covered by my insurance company. I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation. I have read and understand the above.

_____ _____

Signature of Patient or Patient's Legal Guardian Date of Signature