Personal Information

Patient ____ Preferred Name _______________
First Name Initial Last Name

Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐

Responsible Party ____
First Name Initial Last Name

Address ____

City ________________________________ State __________________ Zip ____________________

Home Phone ______________________ Work _______________________ Cell ________________

Birthday________________________________ Social Security Number_________________________

Email Address ____

☐ **Check this box to agree to receive communication with our office via text message or email.**
(Message & data rates may apply.)

Emergency Contact

Name ____ Relation ____________________________

Phone number ____________________________ Phone number _______________________________

Insurance Information

Subscribers Name _______________________ DOB __________ Subscriber # __________________

Insurance Company __________________________________Phone number _____________________

Group # ____________________________ Employer's Name __________________________________

Phone number _______________________

Secondary Insurance Should you carry secondary dental insurance, please note that we will not submit claims to secondary insurance. You will be responsible for paying all fees and submitting to your secondary insurance company.

Referral source

How did you hear about us? ____

Cancellation Policy: please call us by 2:00 p.m. two days prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Tuesday or Wednesday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $100 for a missed hygiene appointment and $500 for a missed surgery appointment.

We collect a $200 non-refundable down payment at the time of scheduling your surgery.

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service**. **If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account.** All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution.

_________________________ ____

Date Signature of patient (responsible party of minor)

26 W. Dry Creek Circle, Ste 540
Littleton, CO 80120

ph: 303.797.1211 fx: 303.798.6006
drjenkins@littletonimplantperio.com