InVision Perio **Patient Information**

NAME _____ MR__ MRS __ MISS __ MS __ DR __

WISH TO BE CALLED / NICKNAME _____

SPOUSE / PARTNER NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE ( ) _____

WORK PHONE ( ) _____

CELL PHONE ( ) _____

I Consent to InVision Perio, using my cell phone number to (choose one or both) ____call or ____text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. _____(initial to give consent)

EMAIL ADDRESS _____

BIRTHDATE _____
month/date/year

SOCIAL SECURITY # _____-_____-_____

REFERRED BY _____

GENERAL DENTIST _____

DO YOU HAVE DENTAL INSURANCE? ___ NO ___ YES
IF YES PLEASE FILL IN THE FOLLOWING

INSURANCE CARRIER _____ PHONE #_____

GROUP NAME _____GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER # _____

PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW

AT TIMES PERIODONTAL/IMPLANT TREATMENT CAN BE PROLONGED. WE RECOMMEND YOU SEE YOUR GENERAL DENTIST <u>AT LEAST</u> ONE TIME PER YEAR FOR AN EXAMINATION AND CONTINUING CARE.

_____ _____
Signature of Patient, Parent or Legal Guardian Date