Paul Binon dds_msd
and associates IMPLANT DENTISTRY & PROSTHODONTICS

PATIENT INFORMATION

PATIENT'S LEGAL NAME: LAST, FIRST	MI	DATE OF BIRTH	PREFERRED NAME
RESPONSIBLE PERSON NAME: LAST, FIRST	SOCIAL SECURITY NUMBER		RELATION TO PATIENT
ADDRESS	CITY/STATE		ZIP CODE
PREFERRED PHONE NUMBER	EMAIL ADDRESS		

How would you like to receive appointment reminders? Please circle your choice.

TEXT PHONE CALL EMAIL

INSURANCE INFORMATION

INSURED NAME: LAST, FIRST	SOCIAL SECURITY OR ID NUMBER	DATE OF BIRTH
INSURANCE COMPANY NAME	PHONE	EMPLOYER NAME

* Please understand that your bill is your own personal responsibility. Insurance is designed to reimburse the policyholder for a loss and is a contract between the policyholder and the company. We do submit claims as a courtesy to all our patients; however, we are not obligated nor required to do so. We generally allow the insurance company up to 30 days to process all claims from the date of submission and longer should they require additional information. If the claim is not paid within a 90 day time period, we ask that you take care of the incurred charges and we reimburse you when the insurance has paid.

REFERRAL INFORMATION

WHO MAY WE THANK FOR REFERRING YOU?	
IF THIS IS A PATIENT OR A DOCTOR, PLEASE PROVIDE THE PHONE NUMBER.	

SIGNATURE _____ DATE _____
(Patient or Parent if patient is a minor)

1158 Cirby Way, Ste. A Roseville, CA 95661 916-786-6676 (P)
binondentalimplants.com info.drbinon@gmail.com 916-786-6820 (F)