Alec J. Temlock, DMD, MS, Inc.
San Francisco Periodontics and Implant Dentistry

Patient Information Questionnaire

Patient Information

Patient's Name: ______________________________ Today's Date: ______________

Social Security Number (Required): ______________________ Date of Birth: ______________

Mailing Address: ____

City: ______________________ State: ____________ Zip Code: ______________

Phone Number: ________________ Email Address: ____________________________

Emergency Contact Information

Emergency Contact Name: __________________________ Phone: ______________

Dental Insurance Information

Insurance Company Name: __________________________ Phone: ______________

Member/Subscriber Identification Number: ____________________________________

Policy Holder: ________________________________ Relationship: ______________

Social Security Number (Required): ______________________ Date of Birth: ______________

Employer: ____________________________________ Phone: ______________

Financial, Insurance, and Cancellation Policy

Payment is expected at the time services are provided. We accept cash and most debit/credit cards. We also offer financing options through CareCredit. We are in-network for many insurance plans; however, your insurance policy is a contract between you, your employer, and your insurance company. We are not part of the insurance contract except to accept the insurance company's fees. As a courtesy, we will attempt to estimate your insurance payments and collect payments from your insurance company. The estimate is only an approximation, and you are ultimately responsible for any and all treatment fees regarding the services provided at this office. It is your responsibility to know your insurance contract's benefits and limitations.

Your treatment plan is individually tailored to your needs and is not based on your dental insurance benefits, coverage, or contract. Some procedures may not be covered by your insurance. We advise you to contact your insurance company directly for specific questions regarding your individual insurance contract, coverage, eligibility, benefits, limitations, authorizations, and payments. It is your responsibility to fully understand the coverage and limitations of your insurance policy. In the event that we do not receive payment from your insurance company within 90 days of filing a claim, the balance will be your responsibility. You are ultimately responsible for all fees associated with treatment regardless of your insurance benefits or coverage.

Failure to show for your appointment or failure to notify the office at least 48 hours in advance to cancel or change your appointment is subject to a $75 cancellation fee.

______________________________________ ______________________

Patient or Guardian Signature Date