



MOUNTAIN TOP
periodontics & implants

8000 E. Prentice Ave. Unit D7
Greenwood Village, CO 80111
(303) 740-0080

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Patient's Email: _____ Pref. Name: _____

Birth Date: _____ Marital Status: M S D W

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SS #: _____

Employer/School: _____

Address: _____

Occupation: _____ Work Phone #: _____

Can you be reached at this number? Yes No Leave a message: _____

Has anyone in your family ever been treated in our office? Y N Name: _____

Spouse/Parent: _____ Work Phone #: _____

Employer: _____

Nearest relative not living with you: _____ Phone #: _____

Physician _____ Phone #: _____

General Dentist _____ Phone #: _____

Whom may we thank for referring you to our office? _____



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DENTAL INSURANCE INFORMATION

Primary Insurance Policy

Policy Holder Name: _____ Birth Date: _____ SS#: _____

Policy Holder's Employer: _____ Relation to patient: _____

Policy Holder's Work Phone #: _____ Insurance Co.: _____

Ins. Co. Address: _____

City/State: _____ Zip Code: _____

Ins. Co. Phone #: _____ Group/Policy #: _____

Secondary Insurance Policy

Policy Holder Name: _____

Birth Date: _____ SS#: _____

Policy Holder's Employer: _____ Relation to patient: _____

Policy Holder's Work Phone #: _____ Insurance Co.: _____

Ins. Co. Address: _____

City/State: _____ Zip Code: _____

Ins. Co. Phone #: _____ Group/Policy #: _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature/Guardian: _____ Date: _____