Notchview Dental Group, L.L.P.

Patient Information

Date _____ Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____ Social Security # _____ - _____ - _____

Birthdate _____ / _____ / _____ If patient is a minor, give parent's/guardian's name _____

If patient is a full-time student, fill in school name _____ Email _____

Employer _____ Occupation _____ Work Phone _____

Responsible Party Name _____
Last First Marital Status

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ - _____ - _____ Birthdate _____ Relationship to Patient _____

Spouse's Name _____ Work Phone _____
Last First Middle

Employer _____ Occupation _____

Social Security # _____ - _____ - _____ Birthdate _____

Emergency Contact _____ Phone (_____) _____

We are complimented that you have selected us to provide dental care for you and your family.
Whom may we thank for referring you to our office? _____

Insurance Information

Insured's Name _____ Insured's Soc.Sec.# _____

Employer _____ Insured's Birthdate _____

Employer's Address _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Ph.# _____

Do you have dual coverage? Yes_____ No_____ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's Soc.Sec # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ph.# _____

Insured's Employer _____ Ph.# _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

FOR OFFICE USE: Reviewed by Dr. _____ Date _____