Northwest Dental Group

Creating Healthy Smiles With Legendary Service!

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ BIRTHDATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____WORK PHONE (_____)_____

EMAIL_____SS#_____

MOBILE PHONE_(_____)_____HOME PHONE_(_____)_____

IN CASE OF EMERGENCY, PLEASE CONTACT_____

PHONE NUMBER_(_____)_____RELATIONSHIP_____

WHOM MAY WE THANK FOR REFERRING YOU _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____BIRTHDATE _____

ADDRESS_____ CITY_____STATE_____ZIP_____

SS#_____ EMPLOYER_____WORK PHONE_(_____)_____

HOME PHONE_(_____)_____ EMAIL _____

INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER ADDRESS_____CITY_____ ST____ZIP_____

POLICY HOLDER BIRTHDATE_____SS#_____DATE EMPLOYED_____

NAME OF EMPLOYER_____ WORK PHONE_(_____)_____

INSURANCE COMPANY_____ TELEPHONE #(_____)_____

INSURANCE COMPANY ADDRESS_____CITY_____ST_____ZIP_____

POLICY #_____GROUP# _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES_____ NO_____ IF YES, COMPLETE THE FOLLOWING:

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER ADDRESS_____CITY_____ ST_____ZIP_____

POLICY HOLDER BIRTHDATE_____SS#_____DATE EMPLOYED_____

NAME OF EMPLOYER_____ WORK PHONE_(_____)_____

INSURANCE COMPANY_____ TELEPHONE #(_____)_____

INSURANCE COMPANY ADDRESS_____CITY_____ST_____ZIP_____

POLICY #_____GROUP# _____

CONTINUED ON REVERSE SIDE

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I AUTHORIZE TREATMENT FOR THE ABOVE-NAMED PATIENT AND AUTHORIZE NORTHWEST DENTAL GROUP TO PERFORM TREATMENTS AS MAY BE NECESSARY FOR PROPER DENTAL CARE.

I AUTHORIZE NORTHWEST DENTAL GROUP TO RELEASE ANY INFORMATION RELATING TO SERVICES PROVIDED FOR INSURANCE CLAIMS.

I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT THE DAY THEY ARE INCURRED.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. **SAME DAY SAVINGS MAY BE OFFERED IF PAYMENT IS RECEIVED AT THE TIME OF SERVICE IF PAID VIA CASH OR CHECK.**

PAYMENT OPTIONS ARE AVAILABLE. PAYMENTS ARE DUE EVERY BILLING PERIOD WITH CREDIT EXTENDED FOR 90 DAYS. FINANCE CHARGES OF 1.5% MPR OR A 1.8% APR WILL BE ADDED ON ANY CHARGES OF 90 DAYS. A $30 HANDLING FEE IS APPLIED FOR ANY RETURNED CHECKS.

X_____ **DATE**_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR