Noll Family Dentistry
www.nolldentistry.com

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

Patient Information

Date_____ Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Birthdate ____/____/____ Social Security # ____ - ____ - ____ Email: _____

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

Emergency Contact _____ Phone (____) _____

Responsible Party or Insured Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____ Social Security # ____ - ____ - ____

Birthdate ____/____/____ Relationship to patient _____

Employer _____ Occupation _____

Employer's Address _____

Dental Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____

Phone (____) _____

Secondary Dental Insurance Information

(if you have 2 dental insurance plans)

If you have dual coverage, please fill out the following:

Spouse's Name _____ Work Phone (____) _____

Social Security # ____ - ____ - ____ Birthdate ____/____/____ Relationship to patient _____

Employer _____ Occupation _____

Employer's Address _____

Insurance Company _____ Group # _____

Insurance Company Address _____ Phone (____) _____

Payment Responsibility

For our patients without dental insurance . . . I understand that all responsibility for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients with dental insurance . . . I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately repsonsible for payment of <u>all</u> dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____