



# Northwest Center for Dentistry

CAMERON CLARK, DMD, PLLC

## NEW PATIENT INFORMATION FORM

Name (Last, First, Middle): \_\_\_\_\_ MARITAL: S / M / D / W

HOME ADDRESS: \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SS NO: \_\_\_ / \_\_\_ / \_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_ SEX: M / F

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ REFERRING PATIENT: \_\_\_\_\_

MEDICAL ALERTS: \_\_\_\_\_ EMERGENCY CONTACT # \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

### PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SS NO.: \_\_\_ / \_\_\_ / \_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_ ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ IND. YRLY. DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAM. YRLY. DEDUCT: \_\_\_\_\_

### ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be dispersed to my insurance plans subscriber, myself or spouse. I am financially responsible for any balances due and authorize the dentist to submit dental claims on my behalf as well as any information needed to process this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers, before and after photos, or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_