CONFIDENTIAL PATIENT INFORMATION

GENERAL INFORMATION

Patient's Name: ______________________________ ❒ Male ❒ Female Birth Date: ________
(Last) (First) (Middle)

❒ Single ❒ Married (Spouse's Name)____________________ ❒ Widow ❒ Divorced ❒ Separated

If full-time student over age 19, name of school/college attending ____________________________

Home Address: ______________________________ City: _______________ State:________

Zip:_________ Phone:_____________ Cell:_____________ Email:_______________________

Driver's License No.: _________________________ Social Security No.: _________________

Employed by ______________________________Occupation: _______________________
(if self, please state business name)

Business Address: ____________________ City: ________________________State:________

Zip: _______________Phone: __________________

Spouse Employed by: _________________________ Occupation: ____________________

Business Address: ________________________ City: _______________ State:________

Zip: _______________Phone: __________________
(ext)

Who Referred you to us ? _____________________________ Phone: ( ) _____________
(We wish to thank them) (ext)

FINANCIAL INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: ___________________________ Relationship: __________ Soc. Sec. No.: ________

Home Address: ____________________ City: _________________________ State:________

Zip: ______________ Phone: ( )____________________
(ext)

IN CASE OF EMERGENCY CONTACT

Name of Nearest Relative: ________________________ Relationship: __________________

Address: ________________________ City:__________________________State:________

Zip: ______________ Phone: ( )____________________
(ext)

DENTAL INSURANCE INFORMATION

This information is necessary to make sure you receive the maximum benefits that you are entitled to. Thank you.

Employee's Name: ______________________________ Soc. Sec. No.: ______________________

Employed by: ____ Birth Date: ______________

Group or
Name of Insurance Co. or Union: ______________________ Subscriber#: ____________________

If patient is covered by more than one dental insurance, please complete the following:

Name of Insured: ____________________ Social Sec. No.: __________ Relationship: ____________

Employed by: ______________________________ Birth Date: ____________________________

Group or
Name of Insurance Co. or Union: ______________________ Subscriber#: ____________________

AUTHORIZATION TO PAY BENEFITS TO DENTIST(S) OF NORTHRIDGE DENTAL GROUP

I hereby authorize payments directly to the above dentist for the surgical and/or dental benefits, provided.

Signature: ____ Date: ______________________

GENERAL CONSENT AND FINANCIAL RESPONSIBILITY STATEMENT

(Including Terms and Conditions)

I hereby authorize the Doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the Doctor to perform or prescribe any and all forms of treatment, medication and therapy deemed necessary. I also authorize and consent that the Doctor may select personnel, as needed, to help facilitate said treatment. I understand that responsibility for payment of dental services provided in this office for me and/or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a $15 charge per month will be added to any balance over 30 days.

In the event of default, I (we) promise to pay legal interest on the interest on the indebtedness, together with collection costs and reasonable attorney fees, as may be required to effect collection.

Signature: ______________________________________ Date: ___________________________