Matt Pilot DDS
5611-119th Ave SE
Ste. 2
Bellevue WA 98006
(425)746-6554

www.newporthillsdental.com

Patient Information

Please complete all information

Chart #. ______
FOR OFFICE USE ONLY

Patient Name: ______ ______ ______ ______
Last First MI Preferred Name

Title: ______ Mr/Ms/Mrs/etc
Gender: ◯ Male ◯ Female
Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______ SS #. ______ Prev. Visit: ______

Email Address: ______ Best time to call: ______

Phone: ______ ______ ______ ______ ______ ______
Home Work Ext Mobile Fax Other

Address: ______ ______
______ ______ ______
City State Zip Code

How were you referred to our office?

______

Who should we contact in case of an emergency? Please type name and contact phone number.

______

Who is responsible for the account

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ______

SS #. ______

Driver's License #: ______

Email Address: ______

Best time to call: ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile ______ Fax ______ Other

Address: ______ ______

______ City ______ State ______ Zip Code

Primary Dental Insurance Information

Name of Insured: ______ ______ ______
Last First MI

Insured's Birth Date: ______ ID #. ______ Group #. ______

Insured's Address: ______ ______
______ ______ ______
City State Zip Code

Insured's Employer Name: ______

Employer Address: ______ ______
______ ______ ______
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______

Insurance Address: ______ ______
______ ______ ______
City State Zip Code

Matt Pilot DDS
5611-119th Ave SE
Ste. 2
Bellevue WA 98006
(425)746-6554

www.newporthillsdental.com

Secondary Insurance Information

Name of Insured: ____________ ____________ ____
Last First MI

Insured's Birth Date: ____________ ID #. ____________ Group #. ____________

Insured's Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ ____________
____________ ____ ____________
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ ____________
____________ ____ ____________
City State Zip Code

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I, the undersigned, authorize the release of treatment information and I hereby assign any insurance benefits to this Doctor. If monthly payments are necessary, I agree to pay interest charges of 1 1/2% (18% yearly) to any balance over 60 days. I also agree that I am financially responsible for all charges whether or not paid by insurance, Medicare & or Medicaid. If it becomes necessary to effect collections of amount the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Matt Pilot DDS
5611-119th Ave SE
Ste. 2
Bellevue WA 98006
(425)746-6554

I consent to the use of my records including but not limited to study models, photographs for the use in educational training. I understand my personal information will be kept confidential.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting any of our staff members.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Response Date: ________