North County Cosmetic and Implant Dentistry

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New Patient Information Form

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: ____________________* ____________________
Address 1 Address 2

____________________* ______* __________*
City State Zip Code

How did you find out about our office?

☐ Yellow Pages ☐ Website/Google ☐ Nwspaper Ad ☐ TV ☐ Radio ☐ Mailer ☐ Other

Other: (Please list below)

____

Emergency Contact Information:
Please list name, phone number, and relationship to patient: *

____
____

Parent, Guardian, or Responsible Party Information

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

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

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

Birth Date: ____________ **SS#:** ____________ **DL#:** ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ____________ ____________ ____ ____________ ____________ ____________
Home Work Ext Mobile Fax Other

Address: ____________ ____________
Address 1 Address 2

____________ ____ ____________
City State Zip Code

Employment Information

The following is for :* ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name:* ____________ **Phone:** ____________

Employer Address: ____________ ____________
Address 1 Address 2

____________ ____ ____________
City State Zip Code

Primary Dental Insurance Information

Name of Insured: ______________________ ______________________ ____

Last First MI

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

Insurance Plan Name: ______________________

Primary Insured's Date of Birth ID # Group Number

____

Primary Insured's Employer

____

Secondary Dental Insurance Information

Name of Insured: ______________________ ______________________ ____

Last First MI

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

Insurance Plan Name: ______________________

Secondary Insured's Date of Birth ID # Group Number

____

Secondary Insured's Employer

____

Medical Insurance Information

Name of Insured: ______________________ ______________________ ____
Last First MI

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

Insurance Plan Name: ______________________

Insured's Date of Birth ID # Group Number

____

Insured's Employer

The following is for : ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: ______________________ **Phone:** ____________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ________ _____-____
City State Zip Code

INFORMED CONSENT - Please read and place a check in each box acknowledging that you have read the statements and agree to the contents set henceforth.

*

☐ I, the undersigned, hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

*

☐ I hereby authorize radiographs, study models, photographs, or any other diagnosis aids deemed appropriate for the treating doctor to make a thorough dental diagnosis. I also authorize all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy agents indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent the doctor to choose and employ such assistance as deemed fit to provide recommended treatment.

*

☐ I understand that appointments are pre-appointed and it is my responsibility to keep my appointment or to reschedule with a minimum of 48 hours notice. Failure to do so may result in a $75.00 charge to my account.

*

☐ I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. As a courtesy to you, this office will prepare and submit insurance claim forms and assist you in collecting payment from your insurance company. I consent and agree to be financially responsible for payment of all services rendered on my behalf, or on behalf of my dependents, if any.

*

☐ I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Acknowledgement of Receipt *

☐ I have received or reviewed a copy of the North County Cosmetic and Implant Dentistry Notice of Privacy Practices and the Dental Materials Fact Sheet. See www.ultimatesmiles.net.

Response Date: ____/____/________