NORTH POINT
DENTAL GROUP, LLC

PATIENT INFORMATION:

Patient Name:

_____

Nickname:_____

Last First Middle

Date of Birth: _____ Age: _____ Sex: ☐M ☐F Social Security #: _____

Mailing Address:

_____

_____

Street City

State Zip

Home Phone: _____ Work: _____ Cell: _____

Primary number to use for appointment confirmation: ☐ Home ☐ Cell ☐ Work

Marital Status: ☐ Minor ☐Single ☐ Married ☐ Divorced Email: _____

Employer: _____ Occupation: _____ No. Yrs. Employed: _____

Emergency Contact: _____ Relation: _____ Phone: _____

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

RESPOSIBLE PARTY INFORMATION:

Name: _____ _ Birth Date: _____

Last First Middle

Mailing Address: _____ _____

Street City State Zip

Social Security #: _____ Email Address: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

PRIMARY INSURANCE INFORMTAION:

Insured's Name: _____ Social Security # _____ Birth Date: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone: _____

Insured's Employer: _____ Phone: _____

SECONDARY INSURANCE INFORMATION:

Insured's Name: _____ Social Security # _____ Birth Date: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone: _____

Insured's Employer: _____ Phone: _____

OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that I am required to pay my "Estimated Patient Portion" and any deductible due, to North Point Dental Group at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. Any portion of treatment that the insurance does not cover is the patient's responsibility. A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that I am responsible for payment in full after (45) days of my treatment, regardless of any delay in payment(s) by my insurance company. I understand that a 1.5% per month late charge may be added to my account for any overdue balance that is my responsibility.

_____

_____

Signature of Patient or Guardian

Date