NORTHRIDGE DENTAL **PATIENT REGISTRATION**

WWW.NORTHDENTALAZ.COM

16215 N. ORACLE TUCSON AZ 85739 **PHONE: 520-825-2195**

Name: _____ Birth date: _____

Nickname: _____**Gender:** male/female **Marital Status:** married/single/widowed

Address: _____

City: _____ State: _____ Zip_____

Phone #'s:

Home: _____ Cell: _____ Work: _____

E-mail: _____ **Permission to contact via:** email/work/home/cell

Spouses Name: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for your referral? _____

_____ My initials indicate that I have been informed of my rights to privacy regarding my personal health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the full Notice of Privacy Practices is posted in the office and is available to me upon my request.

I give my permission for my dental health and treatment to be shared with:

Spouse, parent or guardian: Y or N **Dental specialist:** Y or N

Other: _____ **Relationship**: _____

SIGNATURE OF PATIENT/GUARDIAN_____ Date_____

I _____ hereby authorize the Doctor and /or staff to perform treatment mutually agreed upon by me. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks and I can ask for a complete recital of any possible complications. I authorize the release of any information and/or records rendered to me to other healthcare professionals and/or insurance companies when necessary to aid in my diagnosis and/or treatment. I hereby authorize my dental insurance carrier to pay directly to my dental provider for services. If the insurance claim has been 60 days without full payment the patient is responsible for the remaining due balance immediately. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage. I understand that payment is due at the time of service unless prior arrangements have been made. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees in attempting to collect the balance on the account. I understand that a fee of $50.00 may be assessed for appointment changes with less than 48 business hours notice.

SIGNATURE OF PATIENT/GUARDIAN: _____DATE:_____

Last dental Visit: _____ Last dental cleaning: _____ Periodontal cleaning: Y or N

Premedication for dental appointments: Y or N Joint replacements? Y or N Heart Valves Y or N

Dental Insurance :( )YES ( )NO ( ) Self ( ) Spouse( ) Name: _____ DOB:_____

* Please provide copy of insurance card or fill in the following:

Employer: _____ Group #:_____

Carrier: _____ Ins. Phone: _____

Member ID or Social Security #_____

Ins. Address: _____

I UNDERSTAND I WILL NOT HAVE A CLEANING AT MY INITIAL APPOINTMENT. Y OR N

It is appreciated to submit all paperwork prior to appointment date. We appreciate your trusting us with your SMILE ☺