Northwest Dental Group

Creating Healthy Smiles With Legendary Service!

PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ BIRTHDATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____WORK PHONE (_____)_____

EMAIL_____SS#_____

MOBILE PHONE (_____)_____HOME PHONE(_____)_____

IN CASE OF EMERGENCY, PLEASE CONTACT_____

PHONE NUMBER(_____)_____RELATIONSHIP_____

RESPONSIBLE PARTY *(If patient is under the age of 18 or is not their own guardian)*

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____BIRTHDATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____WORK PHONE(_____)_____

EMAIL_____HOME PHONE(_____)_____

INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER ADDRESS_____CITY_____ ST_____ZIP_____

POLICY HOLDER BIRTHDATE_____SS#_____DATE EMPLOYED_____

NAME OF EMPLOYER_____WORK PHONE(_____)_____

INSURANCE COMPANY_____TELEPHONE # (_____)_____

INSURANCE COMPANY ADDRESS_____CITY_____ST_____ZIP_____

POLICY #_____GROUP#_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES_____ NO_____ IF YES, COMPLETE THE FOLLOWING:

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER ADDRESS_____CITY_____ ST____ZIP_____

POLICY HOLDER BIRTHDATE_____SS#_____DATE EMPLOYED_____

NAME OF EMPLOYER_____WORK PHONE(_____)_____

INSURANCE COMPANY_____TELEPHONE #(_____)_____

INSURANCE COMPANY ADDRESS_____CITY_____ST_____ZIP_____

POLICY #_____GROUP#_____

CONTINUED ON REVERSE SIDE

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I AUTHORIZE TREATMENT FOR THE ABOVE-NAMED PATIENT AND AUTHORIZE NORTHWEST DENTAL GROUP TO PERFORM TREATMENTS AS MAY BE NECESSARY FOR PROPER DENTAL CARE.

I AUTHORIZE NORTHWEST DENTAL GROUP TO RELEASE ANY INFORMATION RELATING TO SERVICES PROVIDED FOR INSURANCE CLAIMS.

I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

I AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT THE DAY THEY ARE INCURRED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. **SAME DAY SAVINGS MAY BE OFFERED IF PAYMENT IS RECEIVED AT THE TIME OF SERVICE IF PAID VIA CASH, CHECK OR CREDIT. SAME DAY SAVINGS WILL NOT BE APPLIED FOR DELTA DENTAL TRANSACTIONS OR WITH PAYMENT OPTIONS INCLUDING CARE CREDIT.**

PAYMENT OPTIONS ARE AVAILABLE. PAYMENTS ARE DUE EVERY BILLING PERIOD WITH CREDIT EXTENDED FOR 90 DAYS. FINANCE CHARGES OF 1.5% MPR OR A 1.8% APR WILL BE ADDED ON ANY CHARGES OF 90 DAYS. A $30 HANDLING FEE IS APPLIED FOR ANY RETURNED CHECKS.

A $50 FEE WILL BE CHARGED TO YOUR ACCOUNT IF YOU DO NOT GIVE 24 HOURS NOTICE WHEN CANCELLING OR RESCHEDULING YOUR APPOINTMENT.

X_____ **DATE**_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT PHOTO AND MEDIA RELEASE

I, _____, DO HEREBY RELINQUISH ANY AND ALL RIGHTS TO PHOTOGRAPHS, PORTRAITS, TRANSPARENCIES, NEGATIVES, VIDEOS, PRINTS, INTRAORAL PHOTOGRAPHS OR OTHER PHOTOGRAPHIC REPRODUCTIONS CAPTURED WITH STILL, MOTION PICTURE, VIDEO, DIGITAL OR OTHER CAMERAS FOR USE BY NORTHWEST DENTAL GROUP FOR THE FOLLOWING PURPOSES:

*ONLINE EDUCATIONAL COURSES	*EDUCATION VIDEOS
*INFORMATIONAL PRESENTATIONS	*EDUCATIONAL PRESENTATIONS OR COURSES
*CONFERENCE PRESENTATIONS	*CONTINUING EDUCATION COURSES
*MARKETING RELATED MATERIALS	*ONLINE TESTIMONIALS

- ☐ I ACCEPT HAVING PHOTOS USED FOR THE ABOVE CIRCUMSTANCES
- ☐ I DECLINE HAVING PHOTOS USED FOR THE ABOVE CIRCUMSTANCES

X_____ **DATE**_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR