NORTHSIDE DENTAL CENTER, PA

Welcome!

Section1/Patient Information:

Name:_____
First Name Middle Initial Last Name

I prefer to be called: _____ If Married, Spouse Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Male/Female: _____ Age: _____ DOB: _____ SSN: _____

Patient Employed by: _____ Occupation: _____

Email Address: _____ Work Phone: _____

Whom may we thank for referring you? _____

Pharmacy: _____ Notify in case of Emergency: _____

Relation to Patient: _____ Emergency Contact Phone: _____

If you have a preferred Dentist, PLEASE CIRCLE ONE:

Dr. James Young, DDS Dr. Larry Chambers, DDS Dr. Frank Hampson, DDS

Section 2/Insurance Information:

In order to control cost, charges or co-pays for office visits are to be paid at the time of service.

Do you have a Dental Insurance Policy: YES ____ NO ____ Are you the POLICY HOLDER? YES ____ NO _____

Policy Holder Name: (First/Middle Initial/Last): _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Private Insurance? YES _____ NO _____ Through Employer? YES _____ NO _____

Name of Employer: _____

Name of Insurance Company: _____

GROUP Number: _____ ID Number: _____

I am legally responsible for payment of bills made by myself or my dependents for dental care by Northside Dental Center.

Print Name: _____ Date: _____

Signature: _____