

WELCOME

Thank you for selecting the office of Alan P. Nohr, D.D.S., P.S. & Associates for your dental healthcare! We will strive to provide you with the best possible dental care. To help you meet all your dental needs, please fill out this form completely in ink. This information is important for our dental records and your health and is, of course, confidential. If you have any questions or need assistance, please ask us - we will be happy to help.

1 PERSONAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Age: _____
(last) (first) (middle)

Circle One: Single Married Divorced Separated Widowed M / F

Parent's Name (if patient is a child): _____ No. of Children: _____

Home Address: _____ Home Phone: _____
(street) (apt #)

(city) (state) (zip) Cell Phone: _____

Your Occupation: _____ Employer: _____ Bus. Phone: _____

Employer Address: _____ Email: _____

Your Social Security #: _____ Driver's License #: _____

Spouse's Name _____ Employer: _____ Bus. Phone: _____

Employer Address: _____

Spouse's Social Security #: _____ Driver's License #: _____

How did you hear about us? Yellow Pages Friend / Relative Other: _____
 Web Site

May we ask who recommended you to our office? _____

Who is responsible for this account? _____

Method of Payment: Cash Insurance Dual Insurance

In case of emergency notify _____ Phone: _____

Nearest Relative: _____ Address: _____ Phone: _____

2 DENTAL INSURANCE

PRIMARY INSURANCE

Name of Insured: _____

Date of Birth: _____

Insurance Company: _____

Group #: _____

Ins. Co. Address: _____

Phone #: _____

ADDITIONAL INSURANCE

Name of Insured: _____

Date of Birth: _____

Insurance Company: _____

Group #: _____

Ins. Co. Address: _____

Phone #: _____

3 AUTHORIZATION AND RELEASE

I hereby authorize Alan P. Nohr, D.D.S., P.S., and Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services, or estimated patient portion quoted.** I agree to be responsible for payment of all services rendered on my behalf or my dependants. The information I have provided for this chart is true and correct to the best of my knowledge.

Signature of patient (or parent if minor)

Date