Dodi Nov, DDS
Cosmetic & General Dentistry

Patient Registration

Patient Information

Patient's Name | Preferred Name

SS # | Birthdate | Sex: ○ Male ○ Female

Who referred you to this office? | Have we seen any member of your family?

Patient Address

City | State | ZIP

Home Phone | Cell Phone

Work Phone | Ext | Email address

Employer | City | Occupation

Spouse / Parent Information (Please circle one)

Name of Spouse / Parent

SS # | Birthdate | Sex: ○ Male ○ Female

Address (if different)

City | State | ZIP

Home Phone | Cell Phone

Work Phone | Ext | Email address

Employer | City | Occupation

In case of emergency, whom shall we notify other than spouse?

Name | Relationship | Phone

Primary Dental Insurance

Employee Name

Employer

Insurance Company Name

Group / Policy #

Employee Id/Ss #

Birthdate

Secondary Dental Insurance

Employee Name

Employer

Insurance Company Name

Group / Policy #

Employee Id/Ss #

Birthdate

Assignment And Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. This office reserves the right to charge for failed appointments or appointments cancelled within 24 hours.

I consent to the taking of photographs and x-rays before, during, and after treatment.

I certify that I have read or had read to me, the contents of this form. I have read the above:

Patient/guardian signature | Date