PATIENT INFORMATION

Patient name _____

Address _____City _____State_____Zip_____

Home Phone _____ Work Phone _____Cell_____

Sex: M___F___ Marital Status: S___ M ___ D ___ W___ Birth Date _____

Social Security # _____ Email Address_____

May we confirm your appointment by text? Yes No

Patient employed by _____

PARENT/SPOUSE INFORMATION

Spouse or Parent Name:_____Soc. Sec. # _____Phone: _____

Spouse or Parent Employed by:_____Work Phone: _____

Other Parent Employed by: _____Work Phone: _____

Whom may we thank for referring you? _____

Emergency contact: _____Phone_____Relation to patient _____

PRIMARY DENTAL INSURANCE (If you have a 2nd insurance please let us know.)

Insurance Company _____ Group #_____

Employer _____

Policy Holder Name _____ Date of Birth _____

Policy Holder Soc Sec #_____ Insurance ID # _____

Policy Holder Address (if not same)_____ Phone _____

City_____State_____Zip_____

ASSIGNMENT AND RELEASE- *PLEASE READ CAREFULLY*

I authorize the release of any information regarding my treatment to any other doctor or dentist that Dr. Nowlin refers me to for additional treatment or consultation. While a treatment plan may be established and presented, it is possible that it may be altered due to subsequent findings during the course of treatment. **IF I CANNOT KEEP MY APPOINTMENT I AGREE TO PROVIDE AT LEAST 24 BUSINESS HOURS NOTICE OR MAY INCUR A CANCELLATION OR BROKEN APPOINTMENT FEE.**

I, the undersigned, certify that I (or my dependents) have insurance coverage and assign directly to Dr. Robert Nowlin and/or Dr. Lisa Nowlin all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy to me, Nowlin Dental Clinic may process insurance claims and submit them to my insurance carrier. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE**. Drs. Nowlin and Nowlin Dental Clinic do not represent any insurance carrier and make no representation as to what services will or will not be covered by my insurance. Any "**estimate**" I receive from Nowlin Dental Clinic is based on information supplied by my insurance carrier and is, as stated, merely an "**estimate**". If the insurance payment is not as it was represented to Nowlin Dental Clinic, Drs. Nowlin and the Clinic are not responsible. The Clinic's fees are set beforehand and have nothing to do with my insurance carrier. Any disagreements I may have about which procedures have or have not been covered must be resolved by me with my employer or insurance carrier and do not change my responsibility for all charges incurred. Any costs incurred in collecting a past due account will be my responsibility. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay the patient portion due at each appointment.

_____ _____ _____

Responsible Party Signature Relationship Date