

**NOLA DENTAL CARE**  
**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ Suite/Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Were you referred by a patient? \_\_\_\_\_ If yes, who can we thank? \_\_\_\_\_

**IF PATIENT IS A MINOR PLEASE FILL OUT MINOR FORM**

**DENTAL INSURANCE**

Insured's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance  
phone#: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Dental Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

I understand I am responsible for payment at the time of treatment and for the fees not paid or covered by my dental insurance. Balances over 30 days will be assessed a bookkeeping fee of 1.5% per month until paid. The person responsible for this account and/or the patient will pay any and all costs including attorney fees if collection becomes necessary. With this signature on file you may process and submit my dental claims to my insurance carrier on my behalf. There may be an hourly charge for appointments not cancelled at least 24 hours in advance.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of responsible party, parent, guardian, patient