Welcome to
North County Dental Group
12324 Oak Knoll Rd
Poway, California 92064
858 748 4802

1. Patient's Information

Today's Date_____

Name:_____
Last **First** **M.I.**

Date of Birth_____ ☐ **Male** ☐ **Female**

Home Address:_____

_____
City **State** **ZIP**

Phone#_____**Cell#**_____

Work#_____

E-Mail_____

SSN _____**Driver's License**_____

Employer_____

Where & When are the best times to reach you?_____

Whom may we thank for referring you?_____

Previous Dentist_____

If patient is a dependent and over the age of 19, does he/she attend school full time? ☐ Yes ☐ No

If yes, what is the name and location of the school?

_____

2. Responsible Party(if different from patient)

His/Her Name:_____

Employer:_____

Wk# _____**SS #**_____

Date of Birth_____**Driver's License**_____

Relationship_____

E-Mail_____

3. Emergency Contact

Name_____

Phone#_____

Relationship_____

4. Insurance
Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City **State** **ZIP**

Insurance Co. Phone #_____

Group #(Plan, Local or Policy #)_____

Insured's Name:_____

Insured's Birth date_____

Relationship to Patient_____

Insured's Address:_____

_____
City **State** **ZIP**

Insured's Phone #_____

Insured's SS#/I.D.#_____

Insured's Empolyer_____

Secondary Insurance

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City **State** **ZIP**

Insurance Co. Phone #_____

Group #(Plan, Local or Policy #)_____

Insured's Name:_____

Insured's Birth date_____

Relationship to Patient_____

Insured's Address:_____

_____
City **State** **ZIP**

Insured's Phone #_____

Insured's SS#/I.D.#_____

Insured's Empolyer_____

Payment is due in full at the time of treatment

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to North County Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date