



NE-DENTAL ASSOCIATES

GIVING SOMETHING TO SMILE ABOUT

Name _____ Social Security # _____

Marital status Single _____ Married _____ Birth date _____

Home Address _____ Home Phone _____ Cell _____

Employer _____ Work Phone _____

Employer Address _____ State _____

Spouse/Parent _____ Social Security # ____-____-____ Telephone _____

Spouse Cell _____ Emergency Contact Name _____ Telephone # _____

If someone other than the PATIENT is responsible for payment, please complete the following:

Name of the responsible party _____ Address _____

City _____ State _____ Zip _____

Relationship to patient _____ Social Security # _____ Telephone # _____

Employer _____ Address _____ Work phone _____

Primary Insurance Co _____

Claims Address _____ Phone _____

Name of Insured _____ Policy # _____ Group # _____

Secondary Insurance _____ Claims Address _____ Phone _____

Name of Insured _____ Policy # _____ Group # _____

If Accident or Injury:

Workers Compensation Carrier or Auto insurance Carrier _____

Address _____ Phone _____

Please sign and return to receptionist:

I acknowledge that I am financially responsible for all charges **regardless of insurance status. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to receive information necessary to secure payment of benefits.**

Signature _____ Date _____

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