# Norwood Dental Patient Information

Patient name _____ Prefer to be addressed as _____

Birthday _____ SSN _____

Home address _____

City/State _____ Zip _____ Home Phone _____

Employer _____ Work Phone _____

Email address _____ Cell Phone _____

Preferred method of contact: Home Phone _____ Work Phone _____ Email _____ Cell _____

Emergency contact: Name _____ Phone _____

Whom may we thank for this referral? _____

**Guarantor** (if not the same as above) – Please note: we cannot bill a non-custodial parent

Name _____ Relationship _____

Birthday _____ SSN _____

Billing address _____

City/ State_____ Zip _____ Home phone _____

Employer _____ Work phone _____

| **Insurance** | **Primary** | **Secondary** |
|---|---|---|
| Insurance Co. Name | _____ | _____ |
| Billing Address | _____ | _____ |
| | _____ | _____ |
| Telephone | _____ | _____ |
| Group # | _____ | _____ |
| Policyholder's Name | _____ | _____ |
| Policyholder's SSN | _____ | _____ |
| Relationship to Patient | _____ | _____ |
| Policyholder's Birthday | _____ | _____ |
| Policyholder's Employer | _____ | _____ |

I hereby authorize Dr. Norwood to furnish information to insurance carriers concerning my dental condition and treatments and I hereby assign to them all payments for dental services to myself or my dependents. I understand that I am responsible for all fees regardless of insurance coverage.

Policyholder Signature _____ Date _____