**NOOGA DENTISTRY**
**MARK S. DILL, DDS, PC**
**AND ASSOCIATES**
*General and Cosmetic Dentistry*

6106 Shallowford Road • Suite 116
Chattanooga, Tennessee 37421
Office: 423.296.1053 • Fax: 423.521.7796

# Welcome

Date: _____

Name: _____ Preferred: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address
if Different: _____ Date of Birth: _____ Social Security: _____

Sex: _____ Single ☐ Married ☐ Spouse's Name: _____

Home Phone: _____ Business Phone: _____ Cell/Pager: _____

E-mail _____

Employer: _____ Occupation: _____

In case of an emergency who may we contact? _____ Phone: _____

Who may we thank for referring you? _____

## Dental Insurance

**Primary**

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Employer: _____

Insured's SS#: _____

Insured's Birthday: _____

Insurance Card ID#: _____

Group #: _____

**Secondary**

Insurance Company: _____

Insurance Company Address: _____

_____

Insurance Company Phone: _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Employer: _____

Insured SS#: _____

Insured's Birthday: _____

Insurance Card ID#: _____

Group#: _____

I UNDERSTAND THAT THE PORTION OF MY TREATMENT NOT COVERED BY INSURANCE IS DUE AND PAYABLE AT EACH VISIT. IF MY INSURANCE COMPANY HAS NOT PAID THEIR PORTION WITHIN 60 DAYS OF BEING PROPERLY BILLED. I UNDERSTAND THAT THE BALANCE WILL BECOME DUE AND PAYABLE FROM ME.

A MISSED APPOINTMENT IS A LOSS TO EVERYONE. A NO-SHOW FEE WILL BE CHARGED FOR MISSED APPOINTMENTS, LESS THAN 48 HOUR NOTICE.

IF THE BALANCE OF MY ACCOUNT IS NOT PAID WITHIN 60 DAYS, I UNDERSTAND THAT I WILL BE CHARGED A FINANCE CHARGE FOR THE CURRENT MONTHLY BILLING PERIOD. THE FINANCE CHARGE WILL BE AN APR OF 18%. I AGREE TO PAY ANY INTEREST, COLLECTION COST AND ATTORNEY FEES INCURRED TO EFFECT COLLECTION ON THIS ACCOUNT.

I UNDERSTAND AND AUTHORIZE THE DOCTORS TO TAKE X-RAYS, STUDY MODELS, AND/OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR FOR A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS, AND PERFORM ANY TREATMENT THAT MAY BE INDICATED.

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

_____ _____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE RELATIONSHIP TO PATIENT(S)