NORDLIE'S
FAMILY DENTISTRY
LIVE · LOVE · SMILE

Mark D Nordlie, DDS, PS
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PATIENT INFORMATION

PATIENT NAME (First, Middle I, Last)			DATE OF BIRTH	SEX ☐ Male ☐ Female
ADDRESS			SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP	MARITAL STATUS ☐ Single ☐ Married	
HOME PHONE	CELL PHONE		WORK PHONE	
EMPLOYER			RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child	
OCCUPATION			E-MAIL ADDRESS	
PHYSICIAN	PHONE		PREVIOUS DENTIST	PHONE
EMERGENCY CONTACT	PHONE		REFERRED BY	PHONE

RESPONSIBLE PARTY

NAME			RELATIONSHIP
ADDRESS (IF DIFFERENT FROM ABOVE)			PRIMARY PHONE
CITY	STATE	ZIP	SECONDARY PHONE

INSURANCE INFORMATION

Primary Coverage		Secondary Coverage	
SUBSCRIBER'S NAME	DATE OF BIRTH	SUBSCRIBER'S NAME	DATE OF BIRTH
ADDRESS (IF DIFFERENT FROM ABOVE)		ADDRESS (IF DIFFERENT FROM ABOVE)	
INSURANCE COMPANY		INSURANCE COMPANY	
SOCIAL SECURITY NUMBER / ID NUMBER		SOCIAL SECURITY NUMBER / ID NUMBER	
GROUP NUMBER		GROUP NUMBER	
EMPLOYER		EMPLOYER	

ASSIGNMENT & RELEASE:

I hereby authorize any dental insurance benefits otherwise payable to me to be paid directly to Mark D Nordlie, DDS, PS. I authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care for me or my minor child. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals as necessary.

Patient or Responsible Party_____ Date_____

CANCELLATION POLICY: Your appointment time has been reserved exclusively for you. As a courtesy to us and other patients, we request 48 hours' notice to avoid a $50 per hour cancellation fee.