Patient Name:____________________________________

Patient Address:_________________________________

Social Security:_________________________________

Name you like to be called by:____________________

Date of Birth_____________ Marital Status____________

NELSEN
Dental Excellence
7920-A Moores Chapel Rd.
Charlotte, NC 28214
704.392.8199
www.CharlotteDentist.org

Patient Phone #_________________________

Patient Cell #___________________________

Patient work #__________________________

Email address:__________________________

Dental Insurance Information

Policy Holder's Name____________________________
Policy Social Security___________________________
Policy Holder's Employer_________________________
Policy Holder's date of birth______________________
Relationship to policy holder:__self__spouse__parent

How did you find our about our practice? ( ) Internet ( ) Referral ( ) Yellow Pages ( ) Drive By
If someone referred you to our practice, whom?_________________Relationship___________

List any person(s) to whom you will allow access of your medical records:

_______________________________________Relationship________________________
_______________________________________Relationship________________________

I hereby authorize the office of Jason Nelsen, DDS to release any information necessary to process any insurance claim for services rendered. I hereby authorize payment from my insurance company or governmental payor to pay directly to Jason R. Nelsen, DDS for services rendered. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

I acknowledge that I have received a copy of Jason R Nelsen, DDS "Notice of Privacy of Personal Health Information"(PHI).

Patient's Signature:_________________________Responsible Party Signature:__________________
Date:_________________________________

WELCOME TO OUR PRACTICE