NORTHWOODS DENTAL

PATIENT REGISTRATION

Patient Information

First Name:________________ Middle Initial:________ Last Name:________________

Address:____

City, State, Zip ____

Home Phone:________________Work Phone:________________Cell Phone:________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date:____________ Age:________ Social Security #:________________

E-Mail:________________________ ☐ I would like to receive correspondences via e-mail.

In case of emergency - nearest relative's name:________________Telephone #:____________

Primary Dental Insurance Information

Name of Insured:________________ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Birth Date:____________ Insured's Social Security #: ________________

Employer: ________________________

Ins. Company: ________________ Group #: ________________

Secondary Insurance Information

Name of Insured:________________ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Birth Date:____________ Insured's Social Security #: ________________

Employer: ________________________

Ins. Company: ________________ Group #: ________________

To the best of my knowledge, the questions on this form have been accurately answered.

I hereby authorize payment directly to Northwoods Dental for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

* I understand and agree that there will be an interest charge of .67% per month on any unpaid balance over 60 days past due. If I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including the fee charged by a collection agency which can be up to 50% of the outstanding balance.

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SIGNATURE OF PATIENT, PARENT, GUARDIAN DATE

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SIGNATURE OF TREATING DOCTOR DATE