NORTHWOODS DENTAL

PATIENT REGISTRATION

Patient Information

First Name: _____ Preferred Name: _____ Middle Initial: _____

Last Name: _____

Address:_____

City, State, Zip_____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ ☐ I would like to receive correspondences via text messages.

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

Birth Date:_____ Social Security #:_____

E-Mail_____ ☐ I would like to receive correspondences via e-mail.

In case of emergency – nearest relative's name_____ Telephone #_____

Relationship of Emergency Contact: ☐ Spouse ☐ Mother ☐ Father ☐ Other _____

Primary 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.

A finance charge of 1.5% or 18% yearly on any unpaid balance over 60 days may be charged.

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN DATE