NORTH POINTE DENTAL PATIENT REGISTRATION

First Name:________________________________ Last Name:______________________________ Middle Initial:______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name__________________

Responsible Party (if someone other than the patient)

First Name:_______________________________ Last Name:______________________________ Middle Initial:________

Address: ____ Address 2:____

City, State, Zip: ____

Home Phone: ______________________ Work Phone: _____________________ Cell Phone: _________________________

Birth Date: __________________ Soc Sec: ______________________ Drivers Lic: _________________________________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: __________________________________ Address 2: __________________________________

City: ___________________________________ State/Zip: ____________________________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: __________________

E-mail: ___________________________________ (this will remain strictly confidential with North Pointe Dental)

Preferred method of contact: ○Cell Phone ○E-mail ○Text ○Home phone ○Work Phone

Gender: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Birth Date: _____________ Age: _________ Soc Sec: ___________________ Driver's Lic: ________________________

Employment Status: ○ Full-time ○ Part-time ○ Retired Student Status: ○ Full-time ○ Part-time

Previous Dentist____

Emergency Contact: Name: _______________________________ phone # __________________________________

How did you hear about North Pointe Dental? ○ Friend/family/co-worker ○ Phonebook ○ Mailer ○ Online ○ Other___________

Whom may we thank for the kind referral? ____

Primary Insurance Information

Name of Insured _____________________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other ______________

Insured SS# ______________________________ Insured Birth Date: _____________________

Employer: _________________________________ Insurance Company: __________________________________

Address: _________________________________ Address: ____

City, State, Zip: _____________________________ City, State, Zip: ______________________________________

Secondary Insurance Information

Name of Insured _____________________________ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other _______________

Insured SS# ______________________________ Insured Birth Date: _____________________

Employer: _________________________________ Insurance Company: _________________________________

Address: _________________________________ Address: ____

City, State, Zip: _____________________________ City, State, Zip: _____________________________________