

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: _____ Email _____ 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 Employer _____ 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 ID# or SSN# _____ 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 ID# _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____