PATIENT REGISTRATION FORM

Patient's Name:_____
(Last) (First) (M.I.) (Mr., Mrs., Ms., Dr.)

Check one: _____ child _____ single _____ married _____ widowed _____ divorced
Age:_____ Date of Birth:_____/_____/_____ SS#:_____
Mailing Address:_____ City/State/Zip:_____

(To respect your privacy, please ONLY list the phone number(s) where we may call you.)
Home Phone:_____ May we leave a message on voice mail? _____ Yes _____ No
Work Phone:_____ May we leave a message on voice mail? _____ Yes _____ No
Cell Phone:_____ May we leave a message on voice mail? _____ Yes _____ No

E-Mail:_____ Student? _____ Yes _____ No P/T F/T
Employed By:_____ Occupation:_____

Name of Spouse:_____ Employer:_____
Age:_____ Date of Birth:_____/_____/_____ SS#:_____

Previous Dentist:_____ Address:_____
Approximate Date of Last Thorough Dental Exam:_____

How did you hear about us?
_____ Referred by:_____ _____ Website _____ Location _____ Phone Book
_____ Other:_____ _____ Newspaper

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~PRIMARY INSURANCE~

Insurance Company:_____ Employer:_____
Insurance Phone #:_____ Group #:_____
Address to Submit Claims:_____
Policyholders' Name:_____ Relationship to Patient:_____
Policyholders' Address:_____
Policyholders' SS# or ID#:_____ Date of Birth:_____/_____/_____

~SECONDARY INSURANCE~

Insurance Company:_____ Employer:_____
Insurance Phone #:_____ Group #:_____
Address to Submit Claims:_____
Policyholders' Name:_____ Relationship to Patient:_____
Policyholders' Address:_____
Policyholders' SS# or ID#:_____ Date of Birth:_____/_____/_____

I understand that my dental insurance is a contract between the insurance carrier and me, and **not** between the insurance carrier and True North Dentistry. **I understand that I am fully responsible, regardless of benefits, for all dental fees at the time of service unless prior arrangements have been made with the office.** Any balance due past the end of the month may be subject to a finance charge computed at 2% per month. I agree to pay all costs and expenses incurred should this account be turned over to an attorney, collection agency, including attorney fees, collection agency fees & court costs. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. If there is an open balance, a statement will be sent to you.

Printed Name:_____ Signature:_____
Date:_____ (Parent or Guardian Signature is required if patient is a minor: under 18 years of age)