

Welcome

to **NORTHWIND DENTAL**

Thank you for choosing Northwind Dental!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have questions or need assistance, please ask us – we're happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ SSN _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College: _____ City _____ State _____
Employer (or Parent/Guardian's Employer) _____ Work Phone _____
Business Address City _____ State _____ Zip _____ Preferred Pharmacy _____
Spouse or Parent/Guardian's Name _____ Phone _____
Person to Contact in Case of Emergency _____ Phone _____
Whom may we thank for referring you? _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Email _____ Home Phone _____ Cell Phone _____
Drivers License # _____ Birthdate _____ SSN _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. We expect payment in full at each appointment.

Cash Personal Check Visa MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____ Date Employed _____
Name of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SSN _____ Date Employed _____
Name of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID# _____
Insurance Co Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max Annual Benefit _____