PATIENT INFORMATION

Name: __Dr. __Mr. __Mrs. __Ms.	Birthdate: / /	Driver's License:
Preferred Name:	Address:	City, State, Zip Code
Home Phone Number: __Preferred ( ) -	Cell Phone Number: __Preferred ( ) -	Email Address:
Marital Status: __ Single __ Married __Divorced __Widowed	Gender: __Male __Female	May we send you text messages? __Y __N May we send you email messages? __Y __N
Responsible Party (if minor): Relationship to Patient:		Spouse's Name:
Occupation:	Employer:	Work Number + Extension: ( ) - EXT_____
Work Address:		City, State, Zip Code:

How did you hear about us? __Referred by family/friend __Online __Insurance Plan __Other:
Whom may we thank for referring you?:

Patient Insurance Information

Primary Insurance - Insurer: __Self __Spouse __Child __Other:_____

Policy Holder Legal Name:	Policy Holder Phone Number: ( ) -	Policy Holder Social Security/Unique ID:
Policy Holder Date of Birth: / /	Policy Holder Employer:	Insurance Company:

Secondary Insurance (if applicable) - Insurer: __Self __Spouse __Child __Other:_____

Policy Holder Legal Name:	Policy Holder Phone Number: ( ) -	Policy Holder Social Security Number: - -
Policy Holder Date of Birth: / /	Policy Holder Employer:	Insurance Company:

I hereby instruct and direct the above Insurance Company(ies) to pay for services rendered by check payable and mailed to Northwoods Dentistry. Payment should be for the professional benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment. A photocopy of this agreement shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney.

Signature:_____ Date:_____

Emergency Contact

Name:	Relationship:	Phone Number: ( ) -

Authorization to Release & Discuss Dental Information

I give the following named person(s) authorization to take messages or speak with the office of Northwoods Dentistry on my behalf.

Name of authorized person:	Relationship:
Name of authorized person:	Relationship:

I authorize Northwoods Dentistry to use the telephone numbers provided to leave messages for reminder calls and other patient matters.

__Home Phone __ Work Phone __Cell Phone __Email

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify Northwoods Dentistry should I wish to change one or more contacts listed above.

Signature:_____

Date:_____

NORTHWOODS DENTISTRY