PATIENT REGISTRATION

Thank you for choosing NorthStar Dental as your dental care home.
So we can best serve you, please take a few minutes to complete this form.

Patient Information

Patient Name ________________________________ Preferred Name ______________________________

Home Phone _______________ Cell ______________ Email ______________________________________

Address _____________________________________ City ________________ State _____ Zip__________

Sex: ☐M ☐F DOB________________ SS# ________-_______-________

Employer ____________________________________ Work Ph. _______________________

Emergency Contact: ___________________________ Emergency Contact Phone#_________________

How did you hear about our office? _______________ Referral's name______________________________

Last Dental Visit __________ Physician's Name ____________________________ Last Visit to Physician_________

Billing Information

Insurance ☐ Self-pay ☐ Flex Plan / HSA ☐ CARE-CREDIT ☐ Other ___________________________________

Primary Dental Insurance ___________________________ Insurance Phone # ____________________________

Group # ______________________ Member # ______________________ SS# ________-_______-________

Subscriber ____________________________ DOB_____________ Relationship to patient ______________________

Secondary Dental Insurance __________________________ Phone # ____________________________

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage as noted above, and assign directly to NorthStar Dental all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I authorize the use of my signature on all insurance submissions. NorthStar Dental practice may use and disclose my personal information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits, or the benefits payable for related services.

Patient/Guardian Signature: ____ **Date:** ___________________