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 _____

Physical Address _____ City _____ State _____ Zip _____

Mailing 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: Cash, Personal Check, Visa, MasterCard.

We expect payment in full after each appointment. Please let us know if you have any questions.

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 _____