NORTHERN FAMILY
DENTISTRY

Patient Registration Form

Responsible Party Information

Name First _____ M.I. _____ Last _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SSN _____ - _____ - _____ Birth Date ____ /____ /_____ Driver's License No. _____ State _____

Phone Home (_____)_____ Work (_____)_____ Cell (_____)_____

***Address** Street _____ P.O. Box or Apt # _____

City _____ State _____ Zip Code _____

Employer Name _____ Employer Street _____

PO Box or Apt # _____ City _____ State _____ Zip Code _____

Present Position _____ How Long _____

Spouse Information

Name First _____ M.I. _____ Last _____

SSN _____ - _____ - _____ Birth Date ____ /____ /_____ Driver's License No. _____ State _____

Phone Home (_____)_____ Work (_____)_____ Cell (_____)_____

Address ☐ Same as above address* Street _____ P.O. Box or Apt #_____

City _____ State _____ Zip Code _____

Employer Name _____ Employer Street _____

PO Box or Apt # _____ City _____ State _____ Zip Code _____

Present Position _____ How Long _____

Patient Information

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Name _____ Birth Date ____ /____ /_____ Sex _____ Age _____ SSN _____-_____-_____

Primary Dental Insurance Company _____ Phone (_____)_____

Address _____ City _____ State _____ Zip Code _____

Policy Holder _____ Group Number _____ ID Number _____

Secondary Dental Insurance Company _____ Phone (_____)_____

Address _____ City _____ State _____ Zip Code _____

Policy Holder _____ Group Number _____ ID Number _____

Name of relative not living with you _____ Phone (_____)_____

Name of friend not living with you _____ Phone (_____)_____

I will be paying today by: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit ☐ Insurance

Please Continue on Back

Our Financial Policy

Thank you for choosing our office for your dental care needs. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. Our hope is that any misunderstandings can be avoided.

Payment is due in full at time of service.
If you have insurance, your estimated portion is due at time of service.

Your dental insurance is YOUR responsibility - but we can help. Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that YOU, the patient, are responsible for the total treatment fee. As a courtesy to you, we do bill your insurance for you. Our estimate to you is based on limited information obtained from your insurance company.

- We accept cash, check, Visa, Mastercard, Discover or Care Credit.
- Our office reserves the right to obtain information on your credit history from a credit reporting agency or third party.
- You may be assessed a missed appointment fee if sufficient notice is not given (48 hours) or no notice is given at all.
- In the situation of children of divorced parents, the person listed as the “Responsible Party” is responsible for payment of the account. No other parties will be billed.
- Interest (1.5% monthly or 18% APR) is added to accounts where fees are 60 days and over from the date service is received.
- Returned checks for non-sufficient funds are subject to a $25 fee added to the account.
- Accounts sent to a collection agency will be assessed reasonable collection costs and/or attorney fees.
- We reserve the right to change this policy as needed.
- A statement charge of $2.50 will be added to any account that is not paid at the time of service. The statement charge will be adjusted off if account is paid in full within one week.
- If you have any questions about your account please call.

I certify that I have read and understand the above financial policy.

Signature _____ Date ___ /___ /_____