NORTHWOOD
Family Dental
CENTER

PATIENT REGISTRATION FORM

This information is requested so that we may provide you the most comprehensive care possible. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

Last Name_____ First Name_____ Middle Initial_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Marital Status_____ DOB_____ SS #_____ Drivers License_____

E-mail_____ ☐ I would like to receive correspondences via e-mail

Employer_____ Work Phone_____

Employer's Address_____

Are you experiencing any dental problems at this time? If so, what?_____

Last dentist visit?_____ What was done then?_____ How did you hear about us?_____

Please list others authorized to discuss your dental account _____
including: ☐ dental ☐ financial

Primary Insurance Information: Name of Insurance Company_____

Address_____ Phone Number_____

Name of Insured_____ SS #_____ DOB_____

Employer Name, Address & Phone_____

Policy Number_____ Group Number_____ Name of Insured_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance Information: Name of Insurance Company_____

Address_____ Phone Number_____

Name of Insured_____ SS #_____ DOB_____

Employer Name, Address & Phone_____

Policy Number_____ Group Number_____ Name of Insured_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

I hereby authorize and request the performance of dental services for myself by Dr. Anthony Pasquale and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Pasquale and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

_____ _____
(Signature) (Date)