New Patient Registration
We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as Completely as you can. If you have any questions, we will be glad to assist you.

Date: ________________________________ **Social Security #** __________/_________/__________

Patient Name: ____
Last **First** **MI**

Address: ____ **Home#** ______________________________

____ **Cell Ph#** ______________________________
City **State** **Zip**

Date of Birth:______/______/______ **Gender: M / F Email:**____

Martial Status: Single / Married / Widowed / Divorce

Responsible Party (if not patient) Name: ____

Relationship to patient: Spouse / Child / Other _______________________ ***DOB:*** ________/_______/_________

Address: ____ ***Phone#:*** ____________________________

Signature to treat patient ____

Dental Insurance Coverage

Prime Insurance

Insured's Name: ______________________________

Insurance Carrier: ____________________________

Insurance Address: ____________________________

Insurance Phone#: _____________________________

Employer Name#: ______________________________

ID/SSN#: _____________________________________

Relationship to Insured: Self / Spouse / Child/ Other

Secondary Insurance

Insured's Name: _____________________________

Insurance Carrier: ___________________________

Insurance Address: ___________________________

Insurance Phone#:_____________________________

Employer Name#: _____________________________

ID/SSN#: ____________________________________

Relationship to Insured: Self / Spouse / Child /Other

How did you hear about North Star Dentistry? Location / Mailer / Internet / Other __________________