

Northwood Dental Associates

510 Northwood Road ◊ Lexington, SC 29072

Patient Registration

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Patient Is: Policy Holder Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____
City, State, Zip: _____
Home Phone #: _____ Work #: _____ Cell #: _____
Date of Birth: _____ Social Sec #: _____ Drivers Lic #: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____
City, State, Zip: _____
Home Phone #: _____ Work #: _____ Cell #: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Date of Birth: _____ Social Sec #: _____ Drivers Lic #: _____
E-mail: _____ I would like to receive correspondences via e-mail
Employment Status: Full Time Part Time Retired Preferred. Dentist: _____
Student Status: Full Time Part Time Preferred. Hygienist: _____
Preferred Pharmacy: _____
Medicaid ID: _____ Last Dental Visit: _____
Employer ID: _____ Effective Date: _____
Carrier ID: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Social Sec #: _____ Insured Date of Birth: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Social Sec #: _____ Insured Date of Birth: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Rem. Benefits: _____ Rem. Deduct: _____