MINOT DENTAL PARTNERS
Center for Endodontics, Periodontics and Implant Dentistry

PATIENT REGISTRATION

Welcome to Minot Dental Partners
Thank you for choosing us as your dental provider

What brings you to Minot Dental Partners? _____
Previous Dentist: _____
How did you hear about us?_____

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address:_____

City:_____ State: _____ Zip:_____

Cellular Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ I would like to receive correspondence via email: Yes/No

Sex: O Female O Male Marital Status: O Married O Single

Birth Date:_____ Age:_____ Social Security: _____-_____-_____

My mouth is: □ very comfortable □ moderately comfortable □ uncomfortable

My smile: □ is excellent □ needs changes □ has no concerns

MY DENTAL HEALTH IS: □Excellent □Good □Fair □Poor

□I want to keep my teeth but only within a certain budget of time and money □I am indifferent

□I will do whatever I must to keep my teeth

Minot Dental Partners **is not under contract (in network)** with any dental insurance plans, however out of courtesy, we will help in submitting all claims to your individual dental insurance.

Primary Insurance Information

Name of Insured: _____
Insured Date of Birth: _____
Insured Soc.Sec: _____
Employer: _____
Member ID: _____

Relationship to Insured: SELF/SPOUSE/CHILD
Insurance Co: _____
Insurance Co Address: _____
City, State, Zip: _____
Phone #: _____
Group#: _____

Secondary Insurance Information (If Applicable)

Name of Insured: _____
Insured Soc.Sec: _____
Employer: _____
Member ID:_____

Relationship to Insured: SELF/SPOUSE/CHILD
Insured Date of Birth: _____
Insurance Co: _____
Address: _____