

PATIENT REGISTRATION

First Name _____ Last Name _____

Preferred Name _____ Married Divorced Widowed Single

Birth Date _____ Gender _____

Address _____

City _____ Zip _____

Phone _____ Cell _____

email address _____

Emergency Contact _____ Relationship _____

Phone _____ Cell _____

Who may we thank for referring you to our practice? _____

Student Status: Full or Part-time

School _____

Responsible Party (if someone other than patient)

Name _____ Relationship to patient _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

Please Note: Your insurance is a contract between you and your insurance carrier. It is your responsibility to know the terms of your policy, i.e. frequency limitations, deductibles, etc. and to inform our office of any changes to your dental insurance. We file claims as courtesy and will accept assignment of benefits when possible, but you will be responsible for all fees regardless of insurance coverage. Please ask if you have any questions.

Primary Dental Insurance Information

Name of Policy Holder (if someone other than patient) _____

Birth Date _____ SS# or ID# _____

Employer _____ Phone _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____ Phone _____

Secondary Dental Insurance Information

Name of Policy Holder (if someone other than patient) _____

Birth Date _____ SS# or ID# _____

Employer _____ Phone _____

Insurance Company _____

Address _____

City _____ State _____ Zip _____ Phone _____

I hereby authorize payment directly to Plage Dentistry of any benefits otherwise payable to me under my dental insurance plan. I understand that I am responsible for all fees for professional services rendered to me or my dependents. I hereby authorize Plage Dentistry to administer any medications and perform any diagnostic and therapeutic procedures as may be necessary for my dental care. I will not hold Plage Dentistry or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form and the medical history form. The information on this page and the medical history are current to the best of my knowledge.

Signature _____ Date _____

Kindly give our office a 24-hr notice should you need to reschedule an appointment so that we may offer that time to another patient.