PATIENT REGISTRATION

First Name______________________________Last Name____

Preferred Name ______________________________________ Married Divorced Widowed Single

Birth Date _____________________Gender________

Social Security Number ______-______-______

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.

<u>Primary Dental Insurance Information</u>

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

Birth Date _________________________ ID#____

Employer ____Phone__________________________________

Insurance Company ____

<u>Secondary Dental Insurance Information</u>

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

Birth Date_________________________ ID# ____

Employer ____Phone ___________________________________

Insurance Company ____

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.