PATIENT REGISTRATION

Patient's Information & Registration

First Name ____________________________

Last Name ____________________________

Married Divorced Widowed Single

Preferred Name ________________________

Birth Date _______________ Gender ________

Social Security __ __ __ - __ __ - __ __ __ __

Address _______________________________

City ____________________ State _________

Zip___________________________________

Home Phone ___________________________

Cell Phone _____________________________

Email _________________________________

Employer ______________________________

****Referred?*** ____________________________

(**Who may we thank for referring you to our practice?)**

Patient's Emergency Contact

Name of Contact ________________________

Relationship ___________________________

Phone Number __________________________

Patient's Responsible Party

*If someone other than patient

Name__________________________________

Relationship to Patient ___________________

Home/Cell Phone ________________________

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.

Patient's Dental Insurance (Primary)

Name of Policy Holder

____

Name of Insurance Company

____

Birth Date of Policy Holder ________________

Subscriber or ID# ________________________

Group# _________________________________

Employer _______________________________

Phone _________________________________

Patient's Dental Insurance Secondary)

Name of Policy Holder

____

Name of Insurance Company

____

Birth Date of Policy Holder ________________

Subscriber# or ID# _______________________

Group# _________________________________

Employer _______________________________

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_________________

(Patient or Guardian must sign if requesting for a minor)

****Our office requires a 24-hr notice should you need to reschedule an appointment.****