



# Patient Registration

# Platinum Dental, Inc.

Please complete the following confidential information.

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Mr. \_\_\_\_ Mrs. \_\_\_\_ Ms. \_\_\_\_ Miss \_\_\_\_ Dr. \_\_\_\_ Other \_\_\_\_

Name you prefer to be address by: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

If patient is a child, Parent's Name: \_\_\_\_\_

School's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Full Time Student: Yes \_\_\_\_ No \_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Other: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male \_\_ Female \_\_

Married \_\_ Single \_\_ Divorced \_\_ Other \_\_

Person to contact in case of an emergency:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Alternate Phone: ( ) \_\_\_\_\_

Name of Person Responsible for this Account: \_\_\_\_\_

Do you have Dental Insurance Coverage? Yes \_\_\_\_ No \_\_\_\_

*If yes, please complete the following information in full so that we may assist you in obtaining your benefits.*

Primary Dental Insurance Company: \_\_\_\_\_ Subscriber is: Self \_\_\_\_ Spouse \_\_\_\_

Group/Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_

Secondary Dental Insurance Company: \_\_\_\_\_ Subscriber is: Self \_\_\_\_ Spouse \_\_\_\_

Group/Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_

*If the insurance coverage is through your spouse, please provide us with Spouse's Name:* \_\_\_\_\_

Spouse's Employer Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ ext.: \_\_\_\_\_

Spouse's Employer Address: \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_ Spouse's Birth Date: \_\_\_\_\_

How did you hear about our office (please circle): Friend Banner Yellow Pages Flyer Website Doctor Other \_\_\_\_\_

Whom may we thank for referring you to us ? \_\_\_\_\_

**Appointments:** When you make an appointment with us, please remember that this time has been reserved for you. A charge of \$50.00 will be made for failed or cancelled hygiene/recall appointments without 24 hours notice. A charge of \$75 per 1/2 hour will be made for failed or cancelled restorative appointments without 24 hours notice.

**Insurance:** To avoid misunderstanding regarding dental insurance, we wish our patients to know that all services rendered are charged directly to the patient and that the patient is personally responsible for payment of fees. As a courtesy, we will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will accept or pay all our fees. Each fee is individual for the individual patient. **You are responsible for all fees not paid by your insurance company.**

You are authorizing us to submit dental claims to your insurance company on your behalf for services rendered at our office.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_