PATIENT REGISTRATION
Ryan J. Platt, DDS and Abigail M. Platt, DDS

Today's Date:_____

PATIENT INFORMATION:

Legal Last Name: _____ Legal First Name:_____

Middle Initial _____ Preferred Name/Nickname: _____

Date of Birth: _____ Pronouns: ☐ he/him ☐ she/her ☐ they/them

Address: _____ City/State/Zip:_____

Home Phone #: _____ Cell Phone #: _____

Email: _____ Social Security #:_____

Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

Patient's Employer: _____ Occupation: _____

In case of emergency, notify:_____ Phone:_____

Who referred you to our office?_____

DENTAL INSURANCE:

Primary Dental Insurance ☐ yes ☐ no

If Yes, Company Name: _____ Phone: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber ID # or SS#: _____ Group Number: _____

Claims Address (Street, City, State, Zip): _____

Secondary Dental Insurance Information ☐ yes ☐ no

If Yes, Company Name: _____ Phone: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Subscriber ID # or SS#: _____ Group Number: _____

ACCOUNT INFORMATION

Person Financially Responsible for Account:_____ Phone #:_____

Address (Street, City, State, Zip): _____

Patient's Relationship to Person Responsible for Account: _____

(TURN OVER)

OFFICE FINANCIAL POLICY

We accept all insurances as out-of-network providers. As a courtesy, we are happy to submit claims for your treatment. We do our best to estimate your portion of the payment due based on the information provided by your insurance company, and any deductible or estimated co-payment amount will be due at the time of treatment. Please remember this is an estimate, and you are responsible for any remaining balance after insurance has paid their portion. If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

For your convenience we accept cash, CareCredit, Visa, MasterCard, Discover, American Express, personal check, money order, or registered check.

Returned Check Fee of $35.00 will be added to your account balance and is collectible.

I have read and understand this financial policy.

Patient signature: _____

CANCELLATION POLICY

As a courtesy to all of our patients, we kindly request two business days notice when rescheduling an appointment. We reserve the right to charge a $50.00 fee for those patients who do not comply with this policy.

I have read and understand this cancellation policy.

Patient signature: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign directly to Drs. Platt all benefits, if any, otherwise payable to me for services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Patient signature: _____