platinum DENTISTRY

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PATIENT REGISTRATION (MINOR)

PATIENT INFORMATION

Today's Date:______________________

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:__________________________________

Social Security #:___________________________________ Who referred you to us?_________________________

In case of emergency, notify:_______________________________________ Phone:___________________________

PRIMARY CAREGIVER/GUARDIAN/PARENT INFORMATION

Name:____ Birthdate: ___________________________________

Employer: ____ Occupation: _________________________________

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: _______________________

MEDICAL HISTORY:

Physician's Name: ____ Date of Last Physical: _____________________

Do you have any of the following? (Check boxes that apply)

☐ Heart Disease	☐ Rheumatic Fever	☐ Hepatitis	☐ Circulatory Problems	☐ General Allergies
☐ Asthma	☐ Pacemaker	☐ Excessive Bleeding	☐ Cancer	☐ Diabetes
☐ Mitral Valve Prolapse	☐ AIDS/HIV	☐ Respiratory Disease	☐ Epilepsy	☐ Thyroid Disease
☐ Epilepsy	☐ Premedication Needed for Dental Treatment		☐ Artificial Heart Valve	☐ Stroke

Are there any other conditions not listed above for which you are under the care of a physician? ☐ YES ☐ NO

If yes, please list conditions here: ____

Please list any medications you are taking at this time:

NAME OF MEDICATION	DOSE	REASON

Do you have any drug allergies or have you ever had an adverse reaction to any medication (including but not limited to: penicillin, dental anesthetics, codeine, erythromycin, sulfa antibiotics)? ☐ YES ☐ NO

If yes, what medication or drug:____

(Turn Over)

MINOR CONSENT

I, being the parent or guardian of ____do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctors, whether or not I am present at the actual appointment when the treatment is rendered.

Parent/Guardian Signature: ____

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.

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: ____