TMJ & Sleep Apnea Center

Patient Registration

Platinum Dental, Inc.

Please complete the following confidential information.

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: _____

Length of Employment: ____Mos./ Yrs. Occupation: _____

If patient is a child, Parent's Name: _____

School's Name: _____

Grade: _____ Full Time Student: Yes ____ No ____

Home Phone: ( )_____

Work Phone: ( )_____

Cell Phone: ( )_____

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: _____

Please complete the following information in full if you would like us to assist you with your insurance claims.

Primary Dental Insurance Company: _____Phone ( )_____

Group/Policy #: _____ID #: _____Subscriber is: Self _____ Spouse _____

Secondary Dental Insurance Company: _____ Phone ( )_____

Group/Policy #: _____ID#: _____Subscriber is: Self _____ Spouse _____

Medical Insurance Company:_____ Phone ( )_____

Group/Policy #:_____ ID#: _____Subscriber is: Self _____ Spouse _____

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):* Banner Flyer Internet Website Yellow Pages Patient Doctor Other

Whom may we thank for referring you to us? _____

I hereby authorize the release of any information required to complete my insurance claims and further authorize payment directly to Platinum Dental, Inc. for any benefits otherwise payable to me for their professional services. A copy of this authorization may be used in place of the original. To avoid misunderstanding regarding insurances, we wish our patients to know that all services rendered are charged directly to the patient and that the patient is **responsible for all fees not paid by the insurance company.**

Signature:_____ Date:_____

(Patient/Responsible party)