PATIENT REGISTRATION (MINOR)
Ryan J. Platt, DDS and Abigail M. Platt, DDS

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	☐ 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

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

Any deductible or estimated co-payment amount will be due at the time of treatment. As a courtesy we will be glad to file your claim for you. We do our best to estimate your portion based on the information provided by your insurance company. 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.

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

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: _____