



PATIENT REGISTRATION

Name (first, last): _____

Address: _____

Birthdate (mm/dd/yyyy): _____ Sex (M/F): _____

SSN: _____ DL#: _____

Occupation: _____

Employer/School: _____

Employer/School Address: _____

Employer/School Phone: _____

Home Phone: _____ Work Phone _____

Cell Phone: _____ Email: _____

(cell phone & email are used for text/electronic appointment reminders/confirmations)

Referred to our office by: _____

Emergency Contact (name and phone): _____

DENTAL INSURANCE

Primary Insured (name, if not self): _____

Primary Insured SSN: _____ Relationship to Patient: _____

Insurance Company: _____

Group Number: _____

Is the Patient covered by additional secondary insurance? YES ___ NO ___

Secondary Insured Name: _____

Secondary Insured SSN: _____ Relationship to Patient: _____

Insurance Company: _____

Group Number: _____

\$25 Fee for Broken Appointments less than 48 hours notice.

Assignment, Release, and Responsibility: I certify that I, and/or my dependants, have insurance coverage and I assign directly to Roberto Bellegarrigue DMD, PA all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The information is accurate and true to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 30 days past due a late fee will be assessed every month until payment is received or the account goes to collections.

Signature and Date: _____

Roberto Bellegarrigue DMD, PA

3331 W. Bearss Ave * Tampa, FL 33618 * Phone: 813-968-5368 * Fax: 813-961-6169

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