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: _____

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