GRANDE DENTAL CARE

Dr. Marcos A. Grande, DDS PLLC

General, Cosmetic, and Implant Dentistry

New Patient Registration Form

Patient Information

Today's Date: _____

Patient's Name: _____ Preferred Name: _____
Last Name First Name Middle Name

Date of Birth: _____ Social Security #: _____ Sex: M or F

Address: _____
City State Zip Code

Home #: _____ Cell #: _____ Other #: _____

Email: _____

Please circle - the best place to reach me is: Home Work Cell Email Text Other: _____

Please Circle: Single Married Long-Term Partner Divorced Separated Widowed Minor

To whom can we thank for referring you to our office? _____

Employment/School Information

Employer/School: _____ Occupation: _____

Work/School Address: _____
City State Zip Code

Work/School #: _____ Work/School Email: _____

Family Information

Person Responsible for Account Finances: _____ Relationship: _____

Spouse's/Significant Other's Name: _____ Phone #: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Family members seen by us: _____

Parent/Guardian Information (For Minors - Patients 18 Years and Under)

Mother's Information ❑ Stepmother ❑ Guardian

Name: _____ Phone #: _____
Last Name First Name Middle Name

Address: _____
City State Zip Code

Date of Birth: _____ Social Security #: _____ Employer: _____

Father's Information ❑ Stepfather ❑ Guardian

Name: _____ Phone #: _____
Last Name First Name Middle Name

Address: _____
City State Zip Code

Date of Birth: _____ Social Security #: _____ Employer: _____

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Emergency Contact Information

Name: _____ Relationship: _____ Phone #: _____

Dental Insurance Information

Primary Insurance:	Secondary Insurance:
Insurance Address:	Insurance Address:
Subscriber's Name:	Subscriber's Name:
Subscriber's Employer:	Subscriber's Employer:
ID# or SS#:	ID# or SS#:
Group #:	Group #:
Date of Birth:	Date of Birth:
Phone #:	Phone #:

Assignment of Benefits

I certify that I and/or my dependent(s), _____,
Patient's Name and/or Dependent(s)' Name

have insurance coverage with _____ and assign directly to Dr. Marcos Grande, DDS
Name of Insurance Company(ies)

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent shall be deemed ongoing until above-named insurance is terminated or I provide a written notice to my insurance carrier that I have revoked this agreement.

Printed name of patient or representative: _____

Signature of patient or representative: _____ Date: _____

Office Policy

Grande Dental Care would like to welcome you to our practice. We are committed to providing you with outstanding dental care. In order for us to provide you with the highest standard of care you deserve, your cooperation is important and appreciated. Our office policy is as follows:

We reserve the right to reschedule late patients. Your appointment time is reserved just for you, because you are important to us. ***We reserve the right to charge $60 for a no-show patient if we are not notified at least 24 hours prior to your scheduled appointment time***. As a courtesy, we do file insurance claims for treatment rendered to you. It is important that you recognize that our relationship is with you, the patient, *not* your insurance company. ***Payment for services rendered is expected in full the day of the appointment***. You will also be responsible for any remaining balance after your insurance has processed and paid the claim.

Signature

I certify that the information provided on this from is accurate to the best of my knowledge:

Printed name of patient or representative: _____

Signature of patient or representative: _____ Date: _____