TRANQUILITY DENTAL
TRUST. RELAX. SMILE.

MELISSA NAIDYHORSKI DDS
MICHAEL PERPICH DDS

Thank you for choosing our practice! We look forward to taking care of all your dental needs. Please fill out this form in ink. If you have any questions regarding this form do not hesitate to ask for assistance, we will be happy to help!

Patient Registration Form (Please fill out completely)

Date _____ How did you hear about us _____

Patient Information: Email Address_____

First Name:_____ Initial:___ Last Name:_____ Preferred Name:_____

Billing Address: _____ City:_____ State:_____ Zip Code:_____

Home Telephone: _____ Mobile #:_____ Work #: _____

Date of Birth:_____ Age: _____ Sex:_____ Marital Status:_____

Social Security Number:_____ College Student (Full time) School Name:_____

Emergency Contact: _____
(Name) (Relation) Phone (#)

Responsible Party Information: (Must be completed if difference from patient information)

Last Name: _____ First Name and MI:_____

Relationship to Patient :_____ Date of Birth:_____ SSN:_____

Billing Address: _____ _____ City:_____ State:_____ Zip Code:_____

Home Telephone: _____ Mobile #:_____ Work #: _____

Dental Insurance Information:

1. Primary Dental Insurance Company Name: _____ Employer: _____
   Claim Address:_____ City:_____ State: ____ Zip Code: _____
   Policy Holder's Name: _____ Date of Birth: _____ SSN:_____
   Group # _____ Union of Local #: _____Subscriber ID #_____

2. Secondary Dental Insurance Company Name: _____Employer: _____
   Claim Address:_____ City:_____ State: ____ Zip Code: _____
   Policy Holder's Name: _____ Date of Birth: _____ SSN:_____
   Group # _____ Union of Local #: _____ Subscriber ID #_____

Patient/Guarantor Signature for Assignment of Benefits and Records Release

I hereby assign transfer and authorize payment directly to Tranquility Dental, P.A. and all rights, title, interest or medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits that are required for medical care. This authorization shall remain valid until I give written notice revoking said authorization.

_____ I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan.

_____ I understand that all financial obligations are due in full the day treatment is rendered if I am not covered by an insurance policy.

Patient Signature: _____ **Date:** _____