

Patient Registration
Thank you for helping us with this information.



*turtle cove
dental*

lee prohofsky d.d.s.

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rogers, mn 55374

p. 763.428.2300
f. 763.428.4031

www.turtlecovedental.com

Date _____

1.
Patient
Information

Patient's Name _____ Birthday _____

Address _____ Phone _____

City _____ State _____ Zip code _____

Social Security Number _____

Parent or Spouse of above _____

2.
Responsible Party
Information
(If different
From above)

Address _____ Phone _____

City _____ State _____ Zip code _____

Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____

3.
Insurance
Information

First Insurance _____ Group Number _____

Name of Policy Holder _____ Birthday _____

Social Security Number _____

Source of Insurance (i. e. Union number or Employer) _____

Insurance Address _____

I hereby authorize payment to Turtle Cove Dental of benefits payable to me under the above policy. I also authorize Turtle Cove Dental to release to the above insurance all information needed to process claims.

Date _____ Signature of Insured Person _____

Second Insurance _____ Group Number _____

Information

Name of Policy Holder _____ Birthday _____

Social Security Number _____

Source of Insurance (i. e. Union number or Employer) _____

Insurance Address _____

I hereby authorize payment to Turtle Cove Dental of benefits payable to me under the above policy. I also authorize Turtle Cove Dental to release to the above insurance all information needed to process claims.

Date _____ Signature of Insured Person _____

4.
Service Charge
Notice

I understand and agree that any charges remaining unpaid for longer than 30 days will be assessed a carrying charge of 1.5% a month. This is an ANNUAL PERCENTAGE RATE OF 18 %.

Signed _____ Date _____

Responsible Party