Essential Endodontics

PATIENT REGISTRATION FORM

Patient Name: _____ Sex: M / F _____
Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____
Address: Street_____City/State/Zip_____
Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
General Dentist: Name _____ Number _____
Referred by: _____ (only if different from General Dentist)
Nearest Pharmacy Name _____ Number _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____
Relationship to Patient:: ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____
Address: Street_____ City/State/Zip_____

Whom to call in case of an emergency:

Name: _____ Relationship: _____
Address:_____
Home Phone: (_____) _____ - _____ Work/Cell Phone: (_____) _____-_____

Insurance Information

Plan Name: _____ I.D. Number: _____
Policy Holder: _____ Group Number: _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F
Policy Holder's Social Security Number: _____ - _____ - _____ Effective Date: _____

Payment

All balances are due at the time of service.

Please indicate method of payment:
[ ] Cash [ ] Check [ ] Credit Card [ ] Interest Free Financing [ ] Dental Insurance

Insurance will be submitted for you and if you pay your fees up front, your reimbursement will be sent to you from the Insurance Company. Alternatively, we will file insurance claim and will charge your credit card on file after insurance company has paid us if there is a balance. A copy of the Explanation of Benefits and credit card receipt will be mailed to you.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Essential Endodontics. I acknowledge that I am financially responsible for payment whether or not covered by insurance. _____ initial

I authorize Essential Endodontics to charge my credit card for any outstanding balance on my account after the insurance company has paid, or monthly until balance is paid in full. _____ initial

Name On Card:_____ Credit Card Type: _____

Credit Card #_____ Exp Date: _____ Code:_____

I certify that all the above information is true to the best of my knowledge.

Signature:_____Date:_____