PATIENT REGISTRATION FORM

Patient Information
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: ________________

Treatment Plan
____
____
____ ______________________ (initial)

Payment Information
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:_______________________

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