

ENDODONTIC AND IMPLANTOLOGY ASSOCIATES

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PATIENT REGISTRATION

Date: _____

Name of Patient: _____	Sex: M F	Date of Birth: _____
Address: _____		Home Phone: _____
City: _____	Zip: _____	Work Phone: _____
Employer: _____	City: _____	Cell Phone: _____
Spouse Name: _____		Date of Birth: _____
Employer: _____	City: _____	Phone: _____
Full Time Student (circle one) Y N	Name of School: _____	
Emergency Contact: _____		Phone: _____
Referring General Dentist: _____	How did you hear about us?: _____	
Patient's e-mail: _____		

Person Responsible For Account: _____	Phone: _____
Address: _____	City: _____ Zip: _____
Relationship To Patient: _____	

DENTAL INSURANCE INFORMATION

Insured's Name: _____	SS#: _____	Date of Birth: _____
Insurance Co. Name: _____	Phone: _____	Group #: _____
Address: _____		
Do You Have Dual Coverage? Yes No	If Yes, Complete The Following:	
Insured's Name: _____	SS#: _____	Date of Birth: _____
Insurance Co. Name: _____	Phone: _____	Group #: _____
Address: _____		

A \$20.00 monthly billing charge will be added to all accounts owed over 90 days.
A \$40.00 fee will be charged for any returned checks.

FORM 1

I have read the above information and answered the questions to the best of my ability. I am financially responsible for all charges incurred during treatment. I understand that insurance coverage inquiries are based on the best available information at the time of the inquiry. Any copayment quoted is an estimate only.

X Signature _____ Date: _____

In order to fulfill our obligation to protect the privacy of our patients, we adhere to the current Health Insurance and Accountability Act of 1966 (HIPAA). We may use or disclose your health information for treatment, to obtain payment for services we provide to you or for healthcare operations. At no other time will this information be used unless requested by you or required by law. Please feel free to request a copy of our privacy practices in its entirety or to discuss any questions you may have regarding our policy.

X Signature _____ Date: _____