PATIENT REGISTRATION

ENDODONTIC AND IMPLANTOLOGY ASSOCIATES

Date: _____

Name of Patient: _____ Sex: M F Date of Birth: _____

Address: _____ Unit#: _____ 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 monthly billing charge of $5.00 will be added to all account owed over 30 days.
A $40.00 fee will be charged for any returned checks.

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. I understand that my co-insurance is an estimate only. Any refunds less than $5.00 will be issued at the request of the payor.

✘ 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 (HIPPA). 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.

✘ Signature _____ Date: _____