Microsurgical Endodontics

Registration

Patient name:_____

Address:_____ City: _____State: ___ Zip: _____

Phone# Home: (___) ___-_____ Work: (___) ___-_____Cell: (___) ___-_____

Preferred phone contact: (please circle) Home Work Cell

How would you like to be addressed by our staff: _____

Social Security #:___-___-____ Date of birth: ___-___-____

Employer:_____Occupation: _____

Address:_____ City: _____State: ___ Zip: _____

Referring dentist:_____

Complete only if information is not provided above

Person responsible for acct:_____Relationship to Patient: _____

Address:_____ City: _____State: ___ Zip: _____

Home phone: (___) ___-_____ Work phone: (___) ___-_____

Do you have dental insurance through your employer? Yes __ No__

If yes, please provide the following information.

Name of Insurance Company:_____ Ins Co. Phone: (___) ___-_____

Address:_____ City: _____State: ___ Zip: _____

Group #:_____

Do you have any other dental insurance coverage? Yes __ No__

This coverage is through: __Spouse __Parent __Other

Their Name:_____ Their Employer: _____

Their Date of Birth___/___/____ Social Security #___-___-____ Work Phone (___) ___-_____

Their Insurance Company:_____ Ins Co. Phone (___) ___-_____

Ins. Co. Address:_____ City:_____State:____Zip: _____

Group #:_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity and authorize release of any information relating to a claim. _____ _____

Signature of Insured Person Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____