

Newport Endodontic Group / Mission Endodontic Group

Patient Registration Form

Date _____

Dr., Mr.

Mrs., Ms _____ Date of Birth _____ Age _____ Married Yes No

Home Address _____ City _____ Zip _____ Phone () _____

Patient Employed By _____ Occupation _____

Business Address _____ City _____ Zip _____ Phone () _____

Social Security Number _____ Drivers License Number _____

Name of Spouse _____ Date of Birth _____ SS# _____ Phone () _____

Spouse Employed By _____ City _____ Zip _____ Phone () _____

If patient is minor, who is legally responsible _____ Phone () _____

Closest Relative _____ Relationship _____ Phone () _____

Referring Dentist _____ Phone () _____

Personal Physician _____ Phone () _____

Dental Insurance Carrier _____ Name of Insured _____

It is customary that all fees for professional services be paid as treatment is rendered. Financial arrangements must be made prior to the start of treatment for completion of payment by the time treatment is completed. We are pleased that many of our patients have insurance to help defray the cost of their dental treatment. Our office will assist you in preparing the forms and collecting from insurance companies. Please be aware that insurance companies make payments based on their own time and fee schedule and that all fees for professional services are the direct responsibility of the patient. Please feel free to discuss any of the above information with our front office staff.

I have read and agree to comply with the above agreement.

Signature of Patient or Responsible Party

Date

OVER PLEASE —>