Patient Registration

Title: _____ Name: _____

DOB: _____ Sex: Female / Male

Address: _____ APT/ Unit # _____

City: _____ ST: _____ Zip: _____

Telephone: Home _____ Cell _____

Email: _____

Referring Doctor Name: _____

Referring Doctor's Telephone: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship: Self / Spouse/ Dependent / Other

Insured Social Security Number: _____ Insured DOB: _____

Insurance Company: _____

Identification Number: _____

Group Number: _____

Group Name: _____

Secondary Insurance Company: _____ ID #:_____

Emergency Contact

Name: _____ Tel#:_____

Relationship: _____

Financial Agreement (Please refer to the Financial Policy given to you)

I have read and understand this document in its entirety; outlining the office and financial policies of Premier Endodontics LLC and agree to these terms.

_____ Date:_____

Signature of patient or parent/guardian: