Premier Endodontics Patient Registration

Name: _____ DOB: _____
SS#_____/_____/_____ Sex: M/ F
Address: _____ ____City: _____
State: _____ Zip: _____
Telephone: Home _____ Cell _____
Email: _____
Referring Doctor's Name: _____
Referring Doctor's Telephone: _____
How did you hear about us:_____

DENTAL INSURANCE INFORMATION
Name of Subscriber: _____ Relationship: Self / Spouse/ Dependent / Other
Social Security Number: _____ DOB: _____
Insurance Company: _____
Policy/ID #: _____
Group Number: _____
Employer/Group Name: _____
Secondary Insurance Company: _____ ID #:_____
Emergency Contact
Name: _____ Tel#:_____
Relationship: _____

Cancellation/ No-Show and Late Arrivals Policy:

Our goal is to provide excellent dental care to you and the rest of our patients, an appointment cancellation policy allows us to be consistent with this. If you are unbale to keep your appointment, please call our office promptly. We ask that you notify us **24 business hours** in advance in order to cancel or reschedule any appointments. This allows for other patients to be scheduled into that appointment.
In the case of a **No-Show** (an appointment that was not cancelled) or **same day** cancellation, a **$55** charge will be charged. If you are running late please contact the office. You may be asked to reschedule if you are **15 min late** to your appointment.

Privacy Practice Notice and consent of limited Authorization and Release Form

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **(you may request a copy if not provided)**

MY SIGNATURE BELOW WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ **Relationship:** _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, BILLING INFORMATION & CONVEY INFORMATION ABOUT MY HEALTH** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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.

_____ _____
Signature of patient or parent/guardian **Date**