

Premier Endodontics Patient Registration

Name: _____ DOB: _____

SS# _____ / _____ / _____ Sex: M/ F/ X

Address: _____ City: _____

State: _____ Zip: _____

Telephone: Home _____ Cell _____

Email: _____

Referring Doctor's Name/Office Name: _____

Referring Doctor's Telephone/Email: _____

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 Dental Insurance Company: _____ ID #: _____

Name of Subscriber: _____ Sub. DOB: _____

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 unable to keep your appointment, please call our office promptly. We ask that you notify us **48 business hours** in advance in order to cancel or reschedule any appointment. This allows for other patients to be scheduled at that time. In the case of a **No-Show** (an appointment that was not cancelled) or **same day** cancellation, a **\$150** charge per appointment 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: _____ Other: _____

Cell Phone Calls/Text and Emails. By providing your cell phone number and/or email address, you consent to receiving such calls or electronic communications at the number or email address provided, including but not limited to, communication attempts (calls, text messages, emails or other electronic means) made by automated telephone dialing system, prerecorded messages or artificial voice. This consent is for Provider and any affiliates, including any and all third-party entities hired by Provider for billing, collections, or customer services.

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

Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, deductibles and maximums which are your responsibility.

Full Payment and/or co-payments **are due at the time** of service. The Patient or guarantor is responsible for all fees and services not covered by the insurance. Balances **30 days** overdue will be automatically processed via card on file, outstanding balances will be sent to collection in addition to any late fees. Please speak to the front desk to find out about arranging a payment plan.

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

Signature of patient or parent/guardian

Date