# MODERN ENDODONTICS, PLLC

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## PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ DOB: _____ SS#: _____

Address: _____
Street Apt # City State Zip Code

Home Phone: (  ) _____ Work Phone: (  ) _____ Cell Phone: (  ) _____

Email Address: _____ Referred by: _____

MODERN ENDODONTICS REQUIRES THE USE OF YOUR SOCIAL SECURITY FOR INSURANCE PURPOSES. IF YOU CANNOT COMPLY, THEN YOU WILL BE REQUIRED TO PAY IN FULL AND HANDLE YOUR INSURANCE ON YOUR OWN. THANK YOU FOR UNDERSTANDING.

Are you: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

RESPONSIBLE PARTY INFORMATION: (If patient is younger than 18 years old)

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ DOB: _____ SS#: _____

Address: _____
Street Apt # City State Zip Code

Home Phone: (  ) _____ Work Phone: (  ) _____ Cell Phone: (  ) _____

DENTAL INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to the insurance company free of charge. We will help you to receive your maximum allowable benefits, but we CANNOT guarantee payment from them. In order to do this, we need your insurance information listed below.

If your insurance has not paid within 60 days of services rendered, you will need to make full payment to this office. You will be reimbursed with your insurance company pays. After 60 days, the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured, and/or the employer through whom the policy was purchased, has a better ability to deal with the insurance company, as they are the client of the insurance company.

Policy Holder: _____ Policy Holder DOB: _____ Policy Holder SS#: _____

Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Employer: _____

Claims Address: _____

Please see back of page for secondary insurance information.

SECONDARY DENTAL INSURANCE INFORMATION:

Policy Holder: _____ Policy Holder DOB: _____ Policy Holder SS#: _____

Insurance Company: _____ Subscriber ID #: _____ Group #: _____

Employer: _____

Claims Address: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____
(If applicable)