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 —>