

# PATIENT REGISTRATION

Today's Date: \_\_\_\_\_

<b>Patient's Name</b>		<b>Sex:</b> M F	<b>Birthdate</b>	<b>Age</b>
<b>Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
Please <b>Circle One:</b> Single Married Separated Widow		<b>Your Soc. Sec. #</b>		
<b>Home Ph.#</b>	<b>Cell Ph.#</b>	<b>E-mail Address</b>		
<b>Your Employer</b>	<b>Work Ph.#</b>	<b>How Long Employed</b>		
Are you a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If patient is minor we need: Mother's DOB:		Father's DOB:
<b>Person responsible for account</b>	<b>Driver's License#</b>	<b>Relationship</b>		
<b>Person responsible for acct (parent if minor)</b>		<b>Responsible party Soc. Sec. #</b>		
<b>Responsible party: Employer</b>	<b>Work Ph.#</b>	<b>Cell Ph.#</b>		

EMERGENCY INFORMATION  
Name, address, & telephone of a relative not living with you.

Reason for this visit \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_ **Dr/Web/Other** \_\_\_\_\_ **Phone** \_\_\_\_\_

**DENTAL INSURANCE INFORMATION (Primary Carrier)**

Insured's name _____	
Insured's employer _____	
Insurance Co _____	
Insurance Co Address _____	
Phone # _____	DOB _____
SS# _____	Group # Local # _____

We schedule appointments specifically for your consult and treatments. Patients are required to give a **24 hour cancellation notice**. Failure to do so will result in a **\$125 cancellation fee**. To make sure we have adequate time for your visit, please arrive 15 minutes before appointment time.

Children under the age of 12 cannot be left unattended in the waiting area. Please make sure you bring a responsible adult to watch small children. We love children but our staff is not responsible for watching children during your treatment.

Only staff members and patients are allowed in treatment operatory area during patient's treatment. **Patient/Responsible party initials** \_\_\_\_\_

## FINANCIAL POLICY

Thank you for choosing Texas Endodontics for your endodontic treatment. Our main concern is that you receive the optimal treatment needed to restore your oral health. Our office wants all of our patients to be able to comfortably afford dental care; therefore, we offer the following financial policy. If you have any questions, please do not hesitate to ask our financial coordinator. We ask that all patients read, initial and sign our financial policy, as well as complete our information sheet prior to seeing the doctor. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and CareCredit, outside financing, and is available upon request and approval. **Please check if you would like more information about financing options.** \_

**Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges.

**Do You Have Insurance?**

- As a courtesy to you we will help you process all your insurance claims. 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. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa, or CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

**Consent:**  
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

**Patient Signature** (Parent of Child) \_\_\_\_\_ **Date:** \_\_\_\_\_