MISSION HILLS
ENDODONTICS

CONFIDENTIAL

Patient Registration Information:

Date: _____

Name: _____ Birthdate: _____
(First) (Mi) (Last)

Welcome to our practice! Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

Address: _____ City: _____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email: _____ SS# _____ Drivers License #: _____

Are you? ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your/ Parent or Guardian's employer: _____Occupation:_____

Business Address: _____City: _____ State: _____ Zip:_____

Emergency Contact: _____ Phone: _____ Relationship: _____

Responsible Party: ☐ Same as above

Name of person for this account: _____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birthdate:_____ SS# _____ Drivers License #: _____

Employer:_____ Occupation:_____

Is this person currently a patient in our office? ☐ Yes ☐ No

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/ or other health practitioners.
I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

X_____ _____
Signature of patient or parent/ guardian if minor Date

I acknowledge I have been informed of this office's Notice of Privacy Practices. Initial here ( )

Late Charges: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.