Registration

SOUTHERN MINNESOTA ENDODONTICS

To help us meet all your healthcare needs, please fill out the form completely.

Patient information *(Confidential)*

First Name:_____ MI: _____ Last Name: _____

Nickname:_____ Birthdate: _____ Sex: Male / Female SS#: _____

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

Home Phone: _____ Mobile:_____ Email: _____

Employer: _____Work Phone: _____

General Dentist: _____ Referred by:_____Physician: _____

Have you ever been a patient of our practice? Yes___ No___ Unsure___

Emergency Contact

Emergency Contact Name:_____ Is this your: Spouse____ Father____ Mother____ Other___

Home:_____ Mobile: _____ Work: _____

Who will be responsible for your account? *(If Self, skip to next section)*

Self___ Spouse___ Father___ Mother___ Other_____

First Name:_____ MI: _____ Last Name: _____

Nickname:_____ Birthdate: _____ Sex: Male / Female SS#:_____

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

Home Phone: _____ Mobile:_____ Email: _____

Employer: _____ Work Phone:_____

Have they ever been a patient of our practice? Yes___ No___ Unsure___

Primary Dental Insurance Information

Primary Insured's Name_____

Sex: Male / Female Relation:_____

SS#: _____

DOB:_____

Insurance Carrier:_____

Group Name: _____

Group #: _____

ID #: _____

Secondary Dental Insurance Information

Secondary Insured's Name_____

Sex: Male / Female Relation:_____

SS#: _____

DOB:_____

Insurance Carrier:_____

Group Name: _____

Group #: _____

ID #: _____

Authorization

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any collection costs if this office determines they are necessary. I understand this office will assist me in submitting claims to my insurance carrier, but I am responsible for any services not covered. I authorize my insurance company to make insurance payments directly to this dental office for services rendered. I authorize release of my records as deemed necessary to third party payers, other professionals or other health care operations. I authorize use of this signature for all insurance submissions. I have received a copy and understand the "Notice of Privacy Practices". I understand that I am giving my consent for use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

X _____ Date:_____

Signature of Patient or Responsible Party