PATIENT REGISTRATION FORM

Patient Name: ____
Date of Birth: _____/_____/_____ Sex: M / F Social Security Number: _______-______-________
Address:____
(Street) (City/State/Zip)
Home Phone: (______) ________-____________ Cell Phone: (______) _________-_____________
Employer Name: _______________________Employer Phone Number: (_____) _____________
Employer Address: ____
(Street) (City/State/Zip)
General Dentist: ____
(Name) (Number)
Nearest Pharmacy ____
(Name) (Number)

Person responsible for bill or parent (Complete only if different from patient)
Guarantor Name: _________________________ Social Security Number: _____ - _____ - _____
Relationship to Patient:: ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____
Address: ____ Phone Number: __________
Employer Name: ___________________________ Employer Phone Number: (___) __________
Employer Address: ____
(Street) (City/Street)

Whom to call in case of an emergency:
Name: ______________________________
Address:____
Home Phone: (______) _______ - ________ Work/Cell Phone: (___) _______-_______
Relationship: _______________

INSURANCE INFORMATION
Plan Name: __________________________________ I.D. Number: ____________________
Address: ____________________________________ Group Number: __________________
Policy Holder: ________________________________ Effective Date: __________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Essential Endodontics. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ____ Date: ____________________

12711 McGregor Boulevard Fort Myers FL 33919 Phone (239) 728-endo Fax (239) 693-3637