

Contra Costa Endodontics Patient Registration

Patient Information

First name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cellular: (____) _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____
Occupation: _____ Employer: _____
Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time School Name: _____
Physicians Name: _____ Phone # : _____
Kaiser Medical #: _____ General Dentist: _____
Preferred Pharmacy: _____ City: _____ Phone: _____

Responsible Party (if someone other than the patient)

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cellular: (____) _____
Birth Date: _____ Social Security: _____ Drivers License: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured S/S#: _____ Insured Birthdate: _____
Employer: _____ Ins Company: _____
Address: _____ Address: _____
City State Zip: _____ City State Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured S/S#: _____ Insured Birthdate: _____
Employer: _____ Ins Company: _____
Address: _____ Address: _____
City State Zip: _____ City State Zip: _____

TERMS AND CONDITIONS

Upon completion of my endodontic therapy in this office, I understand that I must return to my general dentist for restorative care needed to protect the treated tooth/teeth. Failure to do so will lead to the loss of the treated tooth. I hereby authorize payment directly to **Contra Costa Endodontics** of the group insurance benefits otherwise payable to me. I understand that responsibility for payment of services provided in this office is mine, regardless of insurance involvement. I have read the dental materials fact sheet dated May 2004 from Contra Costa Endodontics.

Date: _____ Responsible Party Signature: _____

YOUR PAYMENT IS REQUIRED AT TIME OF SERVICE

(over)