

ESCONDIDO ENDODONTICS

488 East Valley Parkway, Suite 307

Escondido, CA 92025

760 739-1400

PATIENT REGISTRATION

The following confidential information is for our records only.

Mr. Mrs. Ms. Dr.

Date of

Patient name: _____ Birth: _____ M F

Name you preferred to be called: _____

Mailing address: _____

City: _____ State: _____ Zip Code: _____ Home phone: (____) _____

Work phone: (____) _____ Cell phone: (____) _____

Fax Number: (____) _____ E-Mail: _____

Who may we thank for referring you to us? _____

Occupation: _____ Soc. Sec. #: _____

Place of employment: _____

Employment address: _____

DENTAL INSURANCE INFORMATION

Dental insurance is a benefit purchased by or for the patient. Escondido Endodontics is not responsible for the terms of this policy. As a courtesy, we will complete the necessary forms and file a claim for you; however, ***you are responsible for the entire cost of treatment.*** In addition, Escondido Endodontics cannot be responsible for what your insurance company considers as **“usual and customary fees”** since these amounts vary considerably from one carrier to another. Services provided by Escondido Endodontics are charged at the usual and customary rate for endodontic **specialists** performing like services in this geographic area.

Primary Carrier

Secondary Carrier

Insured Person: _____ Insured Person: _____

Soc. Sec. #: _____ Soc. Sec. #: _____

Date of Birth: _____ Date of Birth: _____

Employed by: _____ Employed by: _____

Address: _____ Address: _____

Insurance company: _____ Insurance company: _____

Address: _____ Address: _____

Phone: (____) _____ Phone: (____) _____

Group/Plan #: _____ Group/Plan #: _____

I hereby authorize release of any information, including examinations, diagnosis, and treatment rendered, to my insurance company. This release is solely for the purpose of facilitating billing and reimbursement of benefits, to which I am rightfully entitled, directly to Escondido Endodontics.

Signature: _____ Date: _____