**PATIENT REGISTRATION INFORMATION** **For the office of Whatley Endodontics CONFIDENTIAL**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ General Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_ Soc.Sec # \_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ Sex M or F Please Circle One: Minor Single Married Divorced Widow(er)

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you prefer to receive calls at\_\_\_Work\_\_\_ Home\_\_\_ Cell\_\_\_ Any May we leave a message for you? Y N

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full time Student? Yes or No If Patient is a minor: Mother’s DOB\_\_\_\_\_\_\_\_\_\_\_\_ Father’s DOB\_\_\_\_\_\_\_\_\_\_

Name of Parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Soc. Sec #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Phone # (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Responsible for Account\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_

If you are filling out this form for another person, what is your relationship to that person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information (Primary Carrier) \_**  **Dental Insurance Information (Secondary Coverage)**

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_Subscriber ID/SS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_Subscriber ID/SS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Arrangements**

**Payment is expected in full at each appointment.** Our office is not contracted with any insurance companies and is therefore considered “out of network.” We will be glad to provide you with the dental codes and fees we file with your insurance if you would like to verify your coverage. **As a courtesy, we will file your dental insurance claim for you to get reimbursement**. We do not receive any correspondence from your insurance company after filing the claim; therefore, it is your responsibility to follow up with your insurance if you do not receive any correspondence back from them. We will be glad to provide you with any requested information. Regarding filing of secondary insurance: we must have your primary insurance EOB sent to us from you to be able to file your secondary insurance claim. It will not be filed until this information is received \_\_\_\_\_\_\_\_\_

 ***INITIAL***

For your convenience, we offer the following methods of payment. Please check the option that you prefer.

\_\_\_\_\_ Cash

\_\_\_\_\_ Personal Check

\_\_\_\_\_ Credit Card \_\_\_ Visa \_\_\_ MasterCard \_\_\_ Discover \_\_\_ American Express

Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_\_\_\_\_\_\_\_\_Security Code #\_\_\_\_\_\_\_\_\_\_\_\_\_

**Late Charges**

If you do not pay your entire new balance within **30** days of the monthly billing date, an interest rate of 1 ½% per month (18%Annual Percentage Rate) will be applied on the balance until paid in full.

Failure to pay on this account may result in you being unable to receive additional dental services unless prepayment arrangements are made.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

EXPRESS PRIOR CONSENT TO CONTACT RESPONSIBLE PARTY BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Whatley Endodontics and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and /or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Whatley Endodontics, its employees and/or agents may contact me/us as described above.

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian if Minor or Responsible Party Date