BLAIR ENDODONTICS AND MICROSURGERY

Patient Registration

Title: Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Todays' Date: ______________

First Name: ______________ Middle Initial: ________ Last Name: ______________

Date of Birth: ___ /___ /______ Age: ______ Sex: M ☐ F ☐ S.S #: ______________

Home Address: ____

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Emergency Contact: ________________ Phone: ______________

Occupation: ________________ Employer: ______________

General Dentist: ____________ Phone: __________ Physician: ____________ Phone: ____________

Dental Insurance: Yes ☐ No ☐

Dental Insurance

Primary

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone: ______________

Group #: ______________

Insured's Name: ______________

Relation: ______________

Insured's Birthdate: ______________

Insured's S.S #: ______________

Insured's Employer: ______________

Secondary

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone: ______________

Group #: ______________

Insured's Name: ______________

Relation: ______________

Insured's Birthdate: ______________

Insured's S.S #: ______________

Insured's Employer: ______________

I understand that I am responsible for all charges for dental services and that payment in full is due at the time of treatment unless prior arrangements have been made.
I hereby authorize the office of Blair Endodontics and Microsurgery to affix my name to any claims or documents as related to any benefits to me and my dependents through my place of employment.
I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above.
I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

______________________________ ______________________

Patient's signature (Or guardian) Today's Date