PATIENT REGISTRATION and HISTORY

Welcome to our office.
Thank you for choosing my practice to meet your endodontic needs.
We look forward to becoming a part of your dental health care team.

Name:_____ ☐Mr. ☐Mrs. ☐Ms. ☐Dr.
First MI Last Date of Birth: ____/_____/_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home#:( )_____ Work#:( )_____ Cell#:( )_____
Referring Dentist:_____ General Dentist:_____

OUR POLICY: A **consultation** is performed before any treatment is rendered. All fees are due when services are performed. Fees quoted over the phone are only an estimate; an exact quote cannot be given until the doctor has seen the patient.

Payments Accepted: Cash, Check, MasterCard, Visa & CareCredit (apply here if interested). There is a charge for returned checks and missed appointments.

We accept most dental insurances. As a courtesy, we will submit a claim to your dental insurance company for you but please be aware that you are ultimately responsible for any amount your insurance company does not cover.

DENTAL INSURANCE

1. PRIMARY COVERAGE INFORMATION
Name of Insured:_____ Relationship to Patient: ☐Self ☐Spouse ☐Child
Insured's ID#:_____ Insured's Birthdate:_____/_____/_____
Dental Insurance Company:_____ Phone #:( )_____
Employer:_____ Group #:_____

***if applicable**
2. SECONDARY COVERAGE INFORMATION
Name of Insured:_____ Relationship to Patient: ☐Self ☐Spouse ☐Child
Insured's ID#:_____ Insured's Birthdate:_____/_____/_____
Dental Insurance Company:_____ Phone #:( )_____
Employer:_____ Group #:_____

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

I authorize the release of any dental information necessary in order to process insurance claims and I authorize payment of dental benefits to David W. Cowling, D.M.D. for services rendered. I also understand that I am responsible for paying any co-payment, deductible or any amount that my insurance company does not cover.

X_____ Dated:_____/_____2016
Patient's Signature / Parent or Legal Guardian, if Minor