Contemporary Implantology, Inc. Patient Registration

Name:	DOB:	SS#:
Address:		
City: ST: ZIP:	Driver's Lic. #:	
Home #: Work #:	Cell #:	
Gender: Male Female	**Status**: Child Single Married Divorced Widowed	
E-mail:		

DENTAL INSURANCE – PRIMARY – (Policy holder information)

Policy Holder Name:		DOB:
Employer:	Payor ID:	SS#:
Dental Ins. Co. Name:		Ins.Co.Phone #:
Claim Mailing Address:		
Group #:	Member ID #:	Policy ID#:

DENTAL INSURANCE – SECONDARY – (Policy holder information)

Policy Holder Name:		DOB:
Employer:	Payor ID:	SS#:
Dental Ins. Co. Name:		Ins.Co.Phone #:
Claim Mailing Address:		
Group #:	Member ID #:	Policy ID#:

As a courtesy to you, our office will bill your insurance carrier. We will collect an estimated co-payment from you on the day of your treatment. In any event that your insurance company does not pay for the balance of procedures performed, you are ultimately responsible for your account balance within 60 days from any treatment. By signing this you authorize our office to release any patient records and information needed to process insurance claims on your behalf.

FINANCIAL RESPONSIBILITY IF OTHER THAN SELF

Name:
Address:
Phone:

*Who may we thank for referring you to our office?*____

*Your General Dentist and/ or Clinic Name*______________________________*Phone #*______________

______________________________ ____________________

PATIENT SIGNATURE **DATE**