ULTRA ENDODONTICS
REGISTRATION FORM

(Please Print)

Today's date:	Preferred Pharmacy:

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Preferred Name:	Sex: ❑ F ❑ M
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Social Security No.:
Street address:		City		State, Zip code:
Home phone no.:	Cell phone no.:	Email:		Referred by: ☐ Dr.
Occupation:	Employer:			Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Y ❑ N	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ❑ Other	Subscriber's name:	Birth date:
Please indicate Primary Insurance:			/ /
Group Number:	Member ID:	Social Security Number:	
Occupation:	Employer:	Employer phone no.:	

Name of secondary insurance (if applicable):		Subscriber Name:	Birth Date: / /
Patient's relationship to subscriber:	❑ Self	❑ Spouse ❑ Child	☐ Other
If not SELF, then the Person responsible for bill:	Birth date:	Address (if different):	Phone no:
	/ /		

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Phone no:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider or myself. I also authorize Ultra Endodontics or my insurance company to release any information required to process my claims. I understand advanced imaging will be used as part of my evaluation and treatment and give consent to 3D CBCT dental imaging.

Patient / Guardian Signature Date: