MODERN ENDODONTICS, PLLC

Dr. Christopher Mirucki, DMD   1F Commons Drive #39, Londonderry, NH 03053   603-552-3632

PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: ____________ Last Name: ____________ Middle Initial: ____________

Preferred Name: ____________ DOB: ____________ SS#: ____________

Address: ____
Street   Apt #   City   State   Zip Code

Home Phone: (   ) ____________ Work Phone: (   ) ____________ Cell Phone: (   ) ____________

Email Address: ______________________________ Referred by: ____________

Are you: Married   Single   Divorced   Widowed

RESPONSIBLE PARTY INFORMATION: (If patient is younger than 18 years old)

First Name: ____________ Last Name: ____________ Middle Initial: ____________

Preferred Name: ____________ DOB: ____________ SS#: ____________

Address: ____
Street   Apt #   City   State   Zip Code

Home Phone: (   ) ____________ Work Phone: (   ) ____________ Cell Phone: (   ) ____________

DENTAL INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to the insurance company free of charge. We will help you to receive your maximum allowable benefits, but we CANNOT guarantee payment from them. In order to do this, we need your insurance information listed below.

If your insurance has not paid within 60 days of services rendered, you will need to make full payment to this office. You will be reimbursed with your insurance company pays. After 60 days, the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. The insured, and/or the employer through whom the policy was purchased, has a better ability to deal with the insurance company, as they are the client of the insurance company.

Policy Holder: ____________ Policy Holder DOB: ____________ Policy Holder SS#: ____________

Insurance Company: ____________ Subscriber ID #: ____________ Group #: ____________

Employer: ____

Claims Address: ____

Please see back of page for secondary insurance information.

SECONDARY DENTAL INSURANCE INFORMATION:

Policy Holder: ____________________ Policy Holder DOB: _______________ Policy Holder SS#: ________________

Insurance Company: ______________ Subscriber ID #: __________________ Group #: __________________________

Employer: ____

Claims Address: ____

Patient Signature: ____ Date: _____________________

Parent/Guardian Signature: ____
(If applicable)