RidgeGate ENDODONTICS

## Patient

Last Name:_____ First: _____ MI: _____

Address: _____ City, State Zip: _____

E-mail: _____ Employer: _____

Home Phone: _____ Gender: Male Female

Work Phone: _____ Date of Birth: _____

Cell Phone: _____ SS #: _____

Who may we thank for referring you?_____

## Insurance

Insurance Company: _____

Phone #_____Group #_____ Subscriber #: _____

*IF the insured is NOT the patient, please provide the information below.*

Last Name:_____ First: _____ MI: _____

Address: _____ City, State Zip: _____

E-mail: _____ Employer: _____

Home Phone: _____ Gender: Male Female

Work Phone: _____ Date of Birth: _____

Cell Phone: _____ SS #: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of Patient/Guardian: _____ Date:_____

RidgeGate ENDODONTICS

# Insurance and Financial Policy

_____ _____ _____ _____

Patient's Last Name, First Name Date of Birth

## Insurance

Insurance Company: _____

Phone #_____Group #_____ Subscriber #: _____

*IF the insured is NOT the patient, please provide the information below.*

Last Name:_____ First: _____ MI: _____

Address: _____ City, State Zip: _____

E-mail: _____ Employer: _____

Home Phone: _____ Gender: Male Female

Work Phone: _____ Date of Birth: _____

Cell Phone: _____ SS #: _____

## Financially Responsible

*IF the person financially responsible for the account is NOT the patient, please provide the information below.*

Last Name:_____ First: _____ MI: _____

Address: _____ City, State Zip: _____

E-mail: _____ Relationship: _____

Phone: _____

Home Work Cell

We will bill your insurance company. Your estimated co-payment is due in full at time of service. If the claim is not paid within 60 days or if there is any remaining balance after insurance pays, that amount is your responsibility and is due in full. The benefits belong to you and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is no guarantee of benefits from the insurance company until a claim is received and processed. *Benefits quoted to you are only an estimate provided by the insurance coordinator.* Finance charges will be assessed on all accounts 60 days past due.

Signature of Patient/Guardian: _____ Date:_____