PATIENT REGISTRATION INFORMATION **For the office of Whatley Endodontics CONFIDENTIAL**

Date_____ **General Dentist**_____
Last Name_____ First Name_____ MI____ Soc.Sec # _____
Date of Birth_____ Sex M or F Please Circle One: Minor Single Married Divorced Widow(er)
Mailing Address_____ City_____ State_____ Zip Code_____
Home Phone (_____) _____ Cell Phone (_____) _____ Email_____
Do you prefer to receive calls at___Work___ Home___ Cell___ Any May we leave a message for you? Y N
Occupation_____ Employer _____Work Phone (_____) _____
Employer Address_____ Driver's License #_____
Full time Student? Yes or No If Patient is a minor: Mother's DOB_____ Father's DOB_____
Name of Parent_____ Parent Soc. Sec #_____
Parent Employer_____ Parent Phone # (_____) _____
Person Responsible for Account_____ Relationship_____
Emergency Contact_____Relationship_____Phone # (____) _____
If you are filling out this form for another person, what is your relationship to that person? _____
Name_____ Relationship_____

Dental Insurance Information (Primary Carrier)
Insured's Name_____
Insured's Employer_____
Insured's DOB_____
Insurance Company_____
Insurance Co Address_____
Insurance Phone #_____
Group #_____Subscriber ID/SS_____

Dental Insurance Information (Secondary Coverage)
Insured's Name_____
Insured's Employer_____
Insured's DOB_____
Insurance Company_____
Insurance Co Address_____
Insurance Phone #_____
Group #_____Subscriber ID/SS_____

Financial Arrangements

Payment is expected in full at each appointment or, *if insured, your estimated portion is due.*
As a courtesy we have contacted your insurance company to determine your ESTIMATED patient portion. The patient portion is strictly an ESTIMATE and for various reasons is subject to change once insurance payment has been rendered. We will be glad to provide you with the dental codes we will file out with your insurance and our fees if you would like to verify your insurance coverage. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me**.** _____ ***INITIAL***

For your convenience, we offer the following methods of payment. Please check the option that you prefer.
_____ Cash
_____ Personal Check
_____ Credit Card ___ Visa ___ MasterCard ___ Discover ___ American Express ___ Care Credit

Card # _____ Expiration Date _____Security Code #_____

Late Charges
If you are insured and are only paying your estimated portion, we will mail a check to you if there is a credit on your account after insurance has paid their portion. If after payment is received from insurance company and there is a remaining balance on your account you will be billed for the remaining balance or the credit card information above will be charged to pay the remaining balance after contact with responsible party for balance owed. If you do not pay your entire new balance within **30** days of the monthly billing date, an interest rate of 1 ½% per month (18%Annual Percentage Rate) will be applied on the balance until paid in full.

Failure to pay on this account may result in you being unable to receive additional dental services unless prepayment arrangements are made.
AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.
EXPRESS PRIOR CONSENT TO CONTACT RESPONSIBLE PARTY BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Whatley Endodontics and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and /or use of automatic dialing device, as applicable.
I/We have read this disclosure and agree that Whatley Endodontics, its employees and/or agents may contact me/us as described above.

x_____
Signature of Patient or Parent/Guardian if Minor or Responsible Party Date