Huntington Beach Microscopic
Endodontics & Microsurgery

18377 Beach Blvd
Suite 106 Huntington Beach,
CA 92648
Phone : 7148478600 and 7148478664

CONFIDENTIAL

Date:_____

PATIENT INFORMATION **Have you or a family member been a previous patient in our office? Yes [] No []**

Name: _____ Female ☐ Male ☐
First MI LAST

Date of Birth:_____ Social Security Number:_____ Driver's License #:_____

Address:_____City: _____State:_____Zip:_____

Home Phone: _____ Work:_____ Cell:_____

Employer:_____ Employer's Address:_____

Name of Spouse: _____ Spouse's Social Security #:_____

Name of School (if student):_____ Phone #:_____ State:_____ Zip:_____

In case of Emergency, notify:_____ Phone #:_____ Relationship: _____

Who referred you to our office?: _____ Patient's General Dentist: _____

DENTAL INSURANCE INFORMATION

Primary:

Insurance Company: _____ Group #:_____ Union/Local #:_____

Name of Insured: _____ Relationship: _____ Employer:_____

Date of Birth: _____ Social Security Number:_____

Secondary:

Insurance Company: _____ Group #:_____ Union/Local #:_____

Name of Insured: _____ Relationship: _____ Employer:_____

Date of Birth: _____ Social Security Number:_____

FINANCIAL INFORMATION

If same as above, please check the box and sign below: ☐

All accounts are due and payable at time service is rendered. **If you receive a statement from us, the balance is due in full. This office does not have a monthly billing system. We only bill once after receiving payment from your insurance company.**

By signing this form, you authorize your insurance company to release payment to . You are also allowing our office to receive, send and request payment and or such collection activities on your behalf.

By signing this form you also understand that you are liable for any remaining balances that your insurance company does not pay for whatever reason.

To ensure you and other patients of our office of uninterrupted treatment, it is necessary for all patients to accept and adhere to our definite policies regarding appointments and fees.

Once an appointment is made, please remember this time is reserved for you: **at least 48-business hour advance notice is required to avoid cancellation charges and fees.** *(Surgery cases require 72-business hour notice)*

If under 18, name of Financially Responsible Party:_____Relationship:_____

Date of Birth:_____ Social Security Number:_____ Driver's License #:_____

Address:_____City: _____State:_____Zip:_____

I consent and agree to the above financial agreement and if applicable, authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Financially Responsible Party Date