Welcome to St Johns Endodontics

Name: _____ Nickname: _____

Address: _____ APT:_____

City: _____ State:_____ Zip:_____

Cell Phone_____ Home/Work Phone _____

Email _____ SSN: _____

Parent/Guardian Name: _____Relation:_____
(if applicable)

Referring Dentist: _____ General Dentist: _____
(if different)

Payment is due at time of service, please indicate your method of payment:

☐ Cash ☐ Check ☐ Credit/Debit Card ☐ Care Credit ☐ HSA/FSA

Insurance Policy

We accept most insurance assignments for dental services; however the patient is legally and financially responsible for all cost of dental services regardless of dental insurance coverage. If the insurance does not pay within 60 days of the date the claim was filed, the account becomes due and payable by the patient. It is the patient's responsibility to notify us immediately regarding any changes to benefit coverage. If the insurance company denies a claim, the patient is legally and financially responsible for any service rendered. REMEMBER we will give only an ESTIMATE of the patient's copayment. This is an estimate based on what the insurance company provided our office. If the insurance company does not pay the estimated amount, the patient is fully responsible for the balance. The patient understands that insurance benefits are not a substitute for payment by the patient.

Overdue Fees: Please be advised that should your account be turned over to a collection agency, all costs to collect overdue fees as allowed by law, will be your responsibility, including collection costs and/or attorney fees.

Thank you.

Signature:_____Date:_____

_____ Date:_____
Parent/Guardian Signature (if applicable)

Consent for Use and Disclosure of Health Information

Purpose: This allows our office to contact your dentist and share information about your dental care. In cases where St. Johns Endodontics has been directed not to rely on acknowledgement as a basis to use or disclose health information, this form is used to obtain a patient's consent for our use and disclosure of the patient's protected health information to carry out treatment, payments activities, and healthcare operations, as more fully in our Notice of Privacy Practices.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature:_____Date:_____

_____ Date:_____
Parent/Guardian Signature (if applicable)