WGE West GA Endodontics

REGISTRATION FORM

Patient's Name ____

Date of Birth________________________ Social Security Number_______________________________

Address ____

Street City State Zip Code

Cell phone # _______________________________ Alternate # _________________________________

Email Address ____

Emergency contact name and number ____

If patient is a minor:

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Person responsible for account DOB SSN Phone Number

FINANCIAL AGREEMENT

Please check one:

- **I have dental insurance:**

  If you would like to know whether or not we are an in-network provider with your insurance, please speak with the front office coordinator PRIOR to treatment.

  If you are scheduled for *endodontic therapy (root canal treatment)*, we have verified your insurance coverage and *have estimated* your out of pocket expense. The estimated portion is due in full at the time of treatment. We will file your dental insurance for you.

  If you are scheduled for a *consultation* appointment, the consultation fee is due in full at the time of the consultation visit. We will file your insurance for your reimbursement.

- **I do not have dental insurance:**

  Payment is due in full for all dental services and consultations.

*****I have read and understand the financial policy for West GA Endodontics*****

Signature____ Date______________________