OFFICE REGISTRATION

-PLEASE PRINT-

We would appreciate your completing this form to the best of your ability and then signing where indicated. If you have any questions, do not hesitate to ask one of our staff. They will review the answers with you.

PATIENT INFORMATION:

Name_____
Last **First** **Middle**

Address_____**City**_____**State**_____**Zip**_____

Home Phone _____**Date of Birth** _____**Age**_____ **Female** □ **Male** □

Employer_____ **Bus. Phone**_____
(Patient, Parent or Guardian)

Occupation_____**Cell Phone**_____

PHARMACY: _____

SPOUSE OR PARENT INFORMATION, IF APPROPRIATE:

Name_____**Address**_____
(Spouse, Parent or Guardian) **(If different from patient)**

Employer_____ **Occupation**_____
(Spouse, Parent or Guardian)

Date of Birth _____**Bus. Phone** _____**Cell phone**_____

Person responsible for account_____

INSURANCE INFORMATION:

Primary Dental Ins_____ **Secondary Dental Ins**_____

Insurance ID #_____ **Insurance ID #** _____

Dentist (General) _____ **Dentist (Specialist)** _____

CONSENT TO COMPLETE ENDODONTIC CONSULTATION, DIAGNOSIS AND/OR TREATMENT

I hereby grant authority to: Kyle J. Saisselin, DDS or David M. Dow, DDS, MS — ROCHESTER ENDODONTICS, 6800 Pittsford-Palmyra Rd., Bldg. 100, Suite 110, Fairport, NY 14450 to administer such local anesthetic, and to perform such operations as may be deemed necessary, or advisable in the diagnosis and treatment of this patient.

Treatment, other than emergency care for the relief of pain, will not be started until the course of treatment has been explained to, and has been accepted by, the patient, parent, guardian or relative. Please request additional explanation if anything is unclear.

No guarantee or assurance is given as to the results that may be obtained. You will be responsible to phone this office for a recall appointment in one year for evaluation of healing.

Endodontic treatment is one of the most predictable and successful of dental procedures that save and maintain the natural dentition, with normal cases having a success rate of over 90%. The office staff has explanatory material available about the procedure and medications and we urge you to request and read these.

Very soon after the completion of treatment you must return to your own dentist for permanent restoration of the tooth in every case. If you have any questions please ask the Doctor.

FINANCIAL POLICY: All fees are payable on completion of treatment. We will submit your insurance; and the insurance will pay their portion directly to you. We accept cash, check or credit/debit cards. We also offer CareCredit, which is a health care credit card which, if paid on time monthly and payments completed according to the plan agreement, is free of finance charges. We welcome and encourage frank discussion of fees and services prior to treatment in order to avoid misunderstanding. The financial obligations for the services we render to you are your responsibility.

Thank You For Your Cooperation!

X_____ **DATE** _____
(Parent, guardian or patient signature)

Authorization must be signed by the patient, or by the nearest relative in case of a minor or when the patient is physically or mentally incompetent.
(10/2/2019)