LOVATO
ENDODONTICS

Karen F. Lovato, DDS

PATIENT REGISTRATION
(PLEASE PRINT)

Full Name _____ Date of Birth_____ Age_____

Home Address_____City_____State_____Zip_____

P.O. Box_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____

E-mail_____

Check Approved Methods of Contacting You: ❑Home Phone ❑Cell Phone ❑E-mail ❑Work Phone

Social Security Number_____

Drivers Lic #_____ ❑Male ❑Female

Name of Spouse or Partner_____

Spouse or Partners Phone #_____

Your Employer_____ Work Phone_____

Emergency Contact_____ Relation_____ Phone Number _____

Our office bills individuals in the same household under once account. If you need to have separate accounts, please notify us. **Payment is due upon receipt of services**. As a courtesy to our patients we will bill private dental insurance claims. However, the co-payment and/or deductible specified by your dental plan are due to at the time of service. Please remember that you are ultimately responsible for payment of all services. Payments may be made by cash, check, all major credit cards.

Authorization of Release of Dental Information/Assignment of Benefits
I authorize Lovato Endodontics to release dental information for insurance purposes concerning treatment for myself or the above-named patient while under his care. I agree to pay any fees not covered by my insurance.

Patient/Guardian Signature_____ **Date**_____