Michael D. Doyle, D.D.S., LLC

~ Practice Limited to Endodontics ~

Patient Registration Form

Check: Mr. Mrs. Ms. Dr. Rev. Male Female Minor Single Married Divorced Widowed Separated

Patient's Name: _____
Last Name First Name Middle

Address: _____
Street City State ZIP

Date of Birth: _____Social Security No.:_____
Hobbies: _____Employer/Occupation: _____
Hm Tel: _____ Wk Tel: _____Mobile: _____Email:_____
Person to Contact in Case of Emergency: _____Phone: _____
Whom may we thank for referring you? Who is your family Dentist?
_____ _____

Person Responsible for Account: _____
Social Security No.:_____ Date of Birth: _____
Relationship to Patient: Self_____ Spouse _____ Parent _____ Other _____
Home Phone: _____ Work Phone:_____

Dental Insurance Information:
Name of Insured Employee: _____ Soc. Security No.: _____
Employer: _____ Insurance Co.: _____
Ins. Group No.: _____Ins. Co. Phone: _____
Ins Co. Address: _____
Insured Date of Birth: _____

I authorize my insurance carrier to issue the dental benefits directly to this office, unless otherwise stated and also the release of any information necessary to process the dental insurance.

Signature _____ Date _____

Payment Method – Informed Consent

I understand that Dr. Doyle's office will accept an insurance benefit payment providing the insurance company will remit payment to the office and not the insured. I have been informed that my co-payment is due at the time of service. I understand that insurance estimates given at the time of service are only estimates based on the insurance companies UCR (usual and customary rates) which may or may not be the same as our office fees. I am aware that I am responsible for the entire balance after insurance has paid. I also understand that Dr. Doyle is not a provider for any insurance company, but his office will file my insurance as a courtesy to me. If my insurance company does not remit payment within 30 days, I will pay the remaining balance and will be reimbursed by my insurance company. We gladly welcome any questions regarding fees and discussing your financial options prior to treatment.

Note: All balances are due at the time of service. Please check method of payment below.
[ ] Cash [ ] Check [ ] Visa [ ] MC [ ] Outsource Financing

I also understand root canal treatment is a procedure to retain a tooth which otherwise require extraction. Although root canal treatment has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Additionally variation in canal shapes may complicate treatment resulting in instrument separation in the canal, perforation or a root canal filling that is less desirable. Occasionally, a tooth which has had root canal treatment may require retreatment, surgery, or even extraction, each of which will require an additional charge. I also acknowledge full responsibility for the payment. I understand that a permanent restoration (filling or crown) will be done by my general dentist.

Signature_____Date_____

Updates (Date & Initial) _____ _____ _____ _____

Dr. Doyle has my permission to use my x-rays and photos for presentations and publications – I will be informed prior to any usage. _____ (Patient Initials)