PATIENT INFORMATION

☐Dr. ☐Mr. ☐Mrs. ☐Miss ☐Ms.

Patient_____
Last Name First Name MI Date of Birth

Home Address Street City State Zip

Mailing Address (If Different) Street City State Zip

Home Phone Business Phone Cell Phone E-Mail

Patient's Social Security Number Patient's Employer (please no abbreviations) Occupation

Emergency Contact Relationship Phone Spouse's Name

Referred By General Dentist

DENTAL INSURANCE

Dental Insurance Company Group Number Subscriber ID Number Policy Holder Name

If your spouse or parent is the subscriber of the insurance policy, please provide the following information:

SS#_____, Date of Birth_____Employer_____

RESPONSIBLE PARTY

☐Dr. ☐Mr. ☐Mrs. ☐Miss ☐Ms.

Last Name First Name MI Date Of Birth

Mailing Address Street City State Zip

Home Phone Business Phone Social Security Number Employer

I have completed this form fully and completely, and certify that I am the patient or duly authorized agent of the patient permitted to furnish the information requested. I understand that payment for professional service is the sole responsibility of the patient, and due at the time the endodontic service is rendered. Acceptable forms of payment are cash, check, Visa/MC and American Express. As a courtesy to our patients who have dental insurance we will assist you with benefit issues; however we remind you that your insurance is a contract between you and your carrier. Please be prepared to pay an estimated portion of the charges at the time of your visit and you are responsible for any remaining balance.

DATE **SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY**

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