PATIENT INFORMATION

NAME: _____
Last First Middle Initial Preferred Name

SEX: ❑Male ❑Female STATUS: ❑Single ❑Married ❑Child ❑Other

BIRTHDATE: _____--_____--_____ SOCIAL SECURITY #: _____--_____--_____

ADDRESS: _____
Street City State Zip

TELEPHONE: Home _____ Work _____

Cell_____ Email_____

PATIENT'S EMPLOYER: _____

SPOUSE'S EMPLOYER: _____

EMERGENCY CONTACT PERSON: _____ Telephone: _____

REFERRED BY (GENERAL DENTIST): _____

OFFICE PAYMENT POLICY

PLEASE READ AND SIGN

The best doctor/patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please feel free to discuss the fee at any time. Payment is expected on the day service is rendered. We offer no in-house payment plan; however, we utilize an outside billing agency to assist you with payment arrangements. Please see our front office staff for more information.

Please check the option you prefer:

- ❑ CASH
- ❑ PERSONAL CHECK
- ❑ CREDIT CARD / DEBIT CARD (MasterCard/Visa/American Express/Discover)
- ❑ CARE CREDIT (Must be approved in advance of treatment)

I have read and understand this form: _____
Signature Date

PATIENTS WITH DENTAL INSURANCE: As a convenience to you, we will be glad to assist with filling out insurance forms in order to process a claim to your insurance company on the date of your Root Canal Treatment. Simply fill out the information on the backside. Your insurance company will then send you the reimbursement check directly.

DENTAL INSURANCE

NAME OF INSURED EMPLOYEE: _____

INSURED EMPLOYEE'S SOCIAL SECURITY #: _____ --_____--_____

INSURED EMPLOYEE'S EMPLOYER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INSURANCE COMPANY: _____

_____

GROUP # / PLAN # / ACCOUNT # :_____ _____

SUBSCRIBER # / ID #: _____

SECONDARY DENTAL INSURANCE:

NAME OF INSURED EMPLOYEE: _____

INSURED EMPLOYEE'S SOCIAL SECURITY #: _____ --_____--_____

INSURED EMPLOYEE'S EMPLOYER: _____

NAME OF INSURANCE COMPANY: _____

ADDRESS OF INSURANCE COMPANY: _____

_____

GROUP # / PLAN # / ACCOUNT #: _____

SUBSCRIBER # / ID #: _____