WELCOME

Referred by: _____

General Dentist: _____

Thank you for selecting our endodontic office. We will strive to provide you with the best possible care. To help us meet your endodontic needs, please fill out this form completely. If you have any questions, or need assistance, please ask us. We will be happy to help.

Patients Legal Name: _____ Nickname: _____

Mailing Address: _____ City _____ State _____ Zip _____

Home Phone: (___) _____ Cell Phone: (___) _____

Marital Status: Single Married Divorced Widowed Other Gender: Male Female

Social Security Number: ___/___/___ Date of Birth: ___/___/___

Employer Name: _____ Phone #: (___) _____

Employer Address: _____

Occupation: _____ Retired,How Long _____

Emergency Contact: _____ Phone #: _____

Spouse's Legal Name: _____

Spouse's Social Security Number: ___/___/___ Date of Birth: ___/___/___

Employer Name: _____ Phone #: (___) _____

Employer Address: _____

DENTAL INSURANCE

Name of Insured: _____

Primary Insurance: _____

Billing Address: _____

_____

Phone #: (___) _____ Group#: _____

Insured's ID #: _____

Name of Insured: _____

Secondary Insurance: _____

Billing Address: _____

_____

Phone #: (___) _____ Group#: _____

Insured's ID#: _____

I, the undersigned, understand that only the root canal treatment will be done in this office. The permanent restoration will be done by my regular dentist at his/her office. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination to me during the period of such dental care to third party payors and/or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to take full responsibility for payment for all services rendered on my behalf.

Signature: _____ Date: _____

For patients returning after first office visit, please review and update any changes to your address and dental insurance.

Date reviewed: _____ Patient's Initial's: _____ Date reviewed: _____ Patient's Initial's: _____

Date reviewed: _____ Patient's Initial's: _____ Date reviewed: _____ Patient's Initial's: _____

Date reviewed: _____ Patient's Initial's: _____ Date reviewed: _____ Patient's Initial's: _____