

PATIENT INFORMATION

NAME: _____				
	Last	First	Middle Initial	Preferred Name
SEX:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	STATUS:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Child <input type="checkbox"/> Other
BIRTHDATE:	____	--	____	--
SOCIAL SECURITY #:		____	--	____
ADDRESS: _____				
	Street	City	State	Zip
TELEPHONE:	Home	_____	Work	_____
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 #: _____