# 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 all your endodontic needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.**

Date / /

| | |
|---|---|
| Pt.'s Last Name | First Name |
| Mailing Address | City/Zip |
| Street Address | City/Zip |
| Name of Parent or Guardian (if patient is under 18) | |
| Home Phone Work Phone Cell Phone | Male or Female |
| Social Security Number / / | Date of Birth / / |
| Employer Name and Address | |
| Occupation If Retired, How Long | Marital Status |
| E-Mail Address | |
| Emergency Contact (Not living with you) | |
| Relationship of Emergency Contact | Phone # ( ) - |
| Spouse Last Name | First Name |
| Spouse Social Security # / / | Date of Birth / / |
| Employer and Address | |
| Home Phone | Work Phone |
| Dental Insurance Yes or No (Please Circle) | Secondary Insurance Yes or No |

**I, the undersigned, consent to receive special consultation and, should I agree to accept treatment, I consent to the necessary procedures. I also understand that only the root canal treatment will be done in this office. The permanent restoration (filling, inlay, crown, etc.) will be done by my regular dentist at his office. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Please be aware that delinquent accounts will incur an additional interest charge (1.5% monthly) and collection fees. I agree to pay all collection fees, which may include interest, collection fees, attorney fees, and court costs. A delinquent account is any account, which is over 90 day old from the time of service.**

X _____

Parent Signature or Responsible Party

# Dental Insurance

## Carrier No. 1

| | |
|---|---|
| Insurance Company | |
| Billing Address | |
| City / State / Zip Code | Phone No. |
| Name of Insured (Last Name, First Name, Initial) | |
| Street Address | City/Zip |
| Insured's Social Security No. | Birth Date of Insured / / |
| Employer | Work Phone No. ( ) - |
| Group No. | Policy / ID # |
| | |

## Carrier No. 2

| | |
|---|---|
| Insurance Company | |
| Billing Address | |
| City / State / Zip Code | Phone No. |
| Name of Insured (Last Name, First Name, Initial) | |
| Street Address | City/Zip |
| Insured's Social Security No. | Birth Date of Insured / / |
| Employer | Work Phone No. ( ) - |
| Group No. | Policy / ID # |
| | |

## AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance carrier/carriers to pay directly to the dentist 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.

X _____

Signaute of Patient (or parent/guardian)