

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Birthdate: _____ Soc. Sec.: _____ Gender: Male Female
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: () - _____ Fax: _____ Email: _____
Employer: _____ Phone: () - _____ Occupation: _____
Referred By: _____ General Dentist: _____
Have you been seen in this practice before today? Yes No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Relationship to Patient: patient spouse child other - please specify _____ Soc. Sec.: _____
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext: _____
Mobile: () - _____ Fax: _____ Email: _____
Employer: _____ Phone: () - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins. Co. _____	Ins. Co. _____
Group #: _____ Phone: _____	Group #: _____ Phone: _____
Employer: _____	Employer: _____
Employee (if other than patient)	Employee (if other than patient)
Name: _____	Name: _____
Birthdate: _____ Soc. Sec.: _____	Birthdate: _____ Soc. Sec.: _____
Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female	Subscriber #: _____ Sex: <input type="radio"/> Male <input type="radio"/> Female

Signature (parent or guardian if patient is a minor) _____ Date _____
Signature of authorized representative of Endodontic Associates, P.A. - Hill Center _____ Date _____