ENDODONTIC ASSOCIATES

PATIENT INFORMATION

Today's Date _____

Salutation: □ Dr. □ Mr. □ Mrs. □ Ms. □ Miss

First Name_____

Last Name_____

Middle Name_____

Preferred Name_____

Mailing Address_____

City_____ State_____ Zip_____

Birthdate____/____/_____ SSN_____

Home (_____)_____ □ Best contact

Cell (_____)_____ □ Best contact

Work (_____)_____ □ Best contact

Employer_____

Occupation_____

Referring Dentist_____

Family members seen by us_____

RESPONSIBLE PARTY

(If other than patient or patient is under age 18)

First Name_____

Last Name_____

Billing Address_____

City_____ State_____ Zip_____

Home (_____)_____ □ Best contact

Cell (_____)_____ □ Best contact

Birthdate____/____/_____ SSN_____

Relationship_____

DENTAL PLAN INFORMATION

PRIMARY

Insurance Co. Name_____

Employer_____

Group #_____

Policyholder Information ☐ CHECK IF SAME AS PATIENT

First Name_____

Last Name_____

Ins. ID _____SSN_____

Birthdate___/___/_____ Relationship_____

SECONDARY

Insurance Co. Name_____

Employer_____

Group #_____

Policyholder Information ☐ CHECK IF SAME AS PATIENT

First Name_____

Last Name_____

Ins. ID _____SSN_____

Birthdate___/___/_____ Relationship_____

EMERGENCY CONTACT

Name_____

Home (___) _____ Cell (____)_____

Relationship to patient_____

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