MICRO ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

Please print and fill out form completely. Thank you.

Date:_____ Have you been pre-medicated? ☐ YES ☐ NO

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Male ☐ Female ☐ Social Security #: _____ Occupation: _____

Street Address: _____ Apt/Floor: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Email Address: _____

Whom may we thank for referring you? _____

Who is your General Dentist? _____

Emergency Contact Name: _____ Contact Phone: _____

Are you a student? ☐ YES ☐ NO *If yes, please complete the following line:* _____

College/School Name: _____ City/State: _____

Is the patient a MINOR? ☐ YES ☐ NO *If yes*, please provide parent/guardian name: _____

Payment is expected at the time of service and may be made by the following:

☐ CASH ☐ PERSONAL CHECK ☐ DISCOVER ☐ MASTERCARD ☐ VISA

DENTAL INSURANCE INFORMATION

Subscriber Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SS#: _____

Employer: _____ Employment Date: _____ Work Phone: _____

Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Insurance Co. Address: _____ City/State: _____ ZIP: _____

Secondary Dental Insurance Information (If Applicable)

Subscriber Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SS#: _____

Employer: _____ Employment Date: _____ Work Phone: _____

Insurance Company Name: _____

Subscriber ID #: _____ Group #: _____

Insurance Co. Address: _____ City/State: _____ ZIP: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Relationship to Patient: _____

Street Address: _____ City/State: _____ ZIP: _____

Home Phone: _____ Alternate Phone: _____ Email: _____

Birthdate: _____ Social Security # _____ Driver's license # _____

Employer: _____ Work Phone: _____

PATIENT SIGNATURE: _____ **DATE:** _____