

Endodontic Associates of Central Texas, PLLC

PATIENT INFORMATION

Please Print: Do you have more than one insurance: (please circle) ___ YES ___ NO

Name of Patient _____ Date of Birth _____ Age _____

Name of Parent/Guardian (if patient is under 18 yrs) _____

Patient's Social Security # _____ Sex _____ Race _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Drivers License Number: _____ State Issued: _____

Employer _____ Position _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Name and Telephone Number of Friend or Relative _____

Your Referring Doctor (Where you would like a final report sent) _____

If your Insurance is TRI-CARE(MetLife) Dental Insurance, fill out the following:

Sponsor's Name _____ Sponsor's Social Security No _____

Sponsor's Date of Birth _____ Military Branch _____

Sponsor's Unit _____ Duty Phone No. _____

Rank /Pay Grade _____ ID Card Expiration Date _____

If you have OTHER Dental Insurance, fill out the following:

Subscriber's Name _____ Subscriber's Social Security No _____

Subscriber's Date of Birth _____

Insurance Company _____ Phone No. _____

Group Number _____ Policy Number _____

I understand that forms for insurance claims will be submitted when I provide all the information necessary to complete filing.

I authorize release of any information concerning the health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist. The staff will estimate deductible and co-pay. Payment is due the day services are rendered. I understand and agree that I am ultimately responsible for all costs of dental treatment within 30 days, to include legal fees and any associated court costs. Please also see financial policy form.

Acknowledgement of Review of Notice of Privacy Policies: My signature below also indicates that I have received or reviewed a copy of Endodontic Associates Notice of Privacy Practices.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT (if patient is a minor) _____ DATE: _____