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(United Concordia) 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:_____________________