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: _____ Texting OK? ___YES ___NO

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)_____

YOUR Dental Insurance, (PRIMARY) fill out the following:

Subscriber's Name_____ Sponsor's Social Security No_____

Subscriber's Date of Birth_____ Effective Date of Coverage: _____

Insurance Company _____Phone No._____

Group Number _____ Policy Number _____

If you have OTHER Dental Insurance, (SECONDARY) 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 only when I provide all the information necessary.

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: _____