ENDODONTICS, P. A.

PERSONAL HISTORY

DATE ______

PATIENT'S NAME (PLEASE PRINT) ______

ADDRESS ______

CITY ______

STATE ZIP ______

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ SEPARATED ❒ DIVORCED

SEX: ❒ MALE ❒ FEMALE

PATIENT'S AGE ______ DATE OF BIRTH ______

HOME PHONE NO. ______ WORK PHONE NO. ______

SOC. SECURITY NO. ______

DRIVER'S LIC. NO. ______

PATIENT'S OCCUPATION ______

PATIENT'S EMPLOYER ______

EMPLOYER'S ADDRESS ______

REFERRED BY DR. ______

Have you ever been treated in our office before? ❒ YES ❒ NO

IF SO, WHEN? ______

IN CASE OF EMERGENCY, NOTIFY ______

PHONE NO. ______ RELATIONSHIP ______

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

NAME (FIRST, M.I., LAST) ______

ADDRESS ______

CITY ______

STATE ______ ZIP ______

SEX: ❒ MALE ❒ FEMALE

DATE OF BIRTH ______ SOCIAL SECURITY NO. ______

HOME PHONE NO. ______ WORK PHONE NO. ______

OCCUPATION ______

EMPLOYER ______

ADDRESS ______

CITY ______

ST ______ ZIP ______

PATIENT'S EMAIL ADDRESS ______

CHART NO. ______

DOCTOR ______

REF. DOCTOR ______

Please complete both sides of this form.

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE CO. ______

PHONE NO. ______

ADDRESS ______

CITY ______ ST ______ ZIP ______

ID/AGREEMENT NO. ______ GROUP NAME OR NO. ______

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient) ______

DATE OF BIRTH ______ SOCIAL SECURITY NO. ______

EMPLOYER'S NAME ______

ADDRESS ______

HOW IS PATIENT RELATED TO THE SUBSCRIBER?

❒ SPOUSE ❒ DEPENDENT

DATE ______

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE CO. ______

PHONE NO. ______

ADDRESS ______

CITY ______ ST ______ ZIP ______

ID/AGREEMENT NO. ______ GROUP NAME OR NO. ______

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (If different from patient) ______

DATE OF BIRTH ______ SOCIAL SECURITY NO. ______

EMPLOYER'S NAME ______

ADDRESS ______

HOW IS PATIENT RELATED TO THE SUBSCRIBER?

❒ SPOUSE ❒ DEPENDENT

What percentage will this Insurance Co. cover? ______ %

Signature ______

Fill out information to the left ONLY if you have dental insurance

OVER ➢