PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ◯ Male ◯ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

Referred By: _____ General Dentist: _____

Have you been seen in this practice before today? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◯ Male ◯ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◯ Male ◯ Female

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Southeastern Endodontics Date