

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell # \_\_\_\_\_

E-mail address \_\_\_\_\_ May we confirm appts. via e-mail? \_\_\_\_\_

Marital Status M \_\_\_ W \_\_\_ S \_\_\_ D \_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Name & Phone # of your pharmacy \_\_\_\_\_

What is the best phone # to reach you between the hours of 9:00 a.m.-5:00 p.m.? \_\_\_\_\_

**Person to contact in case of emergency (*not living with you*)**

\_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Did you visit our website [www.tricitiesendo.com](http://www.tricitiesendo.com)? \_\_\_ Yes \_\_\_ No

## DENTAL HISTORY

Name of your general dentist \_\_\_\_\_

Did you bring x-rays? \_\_\_ Have you had a previous root canal treatment? \_\_\_\_\_

Have you ever had treatment for periodontal disease? \_\_\_ (ex. pyorrhea, gum disease)

Have you ever had a serious problem with dental treatment? \_\_\_ If so, please explain

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Are you missing any teeth? \_\_\_ Do you have implants? \_\_\_

Are you wearing removable dental appliances? \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ SS# or ID# \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Address \_\_\_\_\_

Group # \_\_\_\_\_ Insurance company Phone # \_\_\_\_\_

Secondary insurance company (If any)

Subscriber's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber's Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ SS# or ID# \_\_\_\_\_

Name of insurance company \_\_\_\_\_ Address \_\_\_\_\_

Group # \_\_\_\_\_ Insurance company phone # \_\_\_\_\_

## FINANCIAL INFORMATION

**Payment is due at time of service.**

As a courtesy to our patients we will file your insurance, after treatment is completed for reimbursement to you.

Please give receptionist a copy of your **dental** insurance card.

Service charges of \$15.00 will be added to returned checks.

Your signature gives the doctor & staff permission to treat you, to release information to the insurance company, your dentist, and to obtain a credit history.

You also agree to the financial terms above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

