WELCOME TO ENDODONTICS OF THE OZARKS

Patient Name _____ Date_____

Physical Address _____ City_____ State_____ Zip_____

Mailing Address_____ City_____State_____ Zip_____

Date of Birth _____ Home Phone ( )_____ Cell Phone ( )_____

Social Security # _____ Sex: M/F Married: Y/N Email: _____

Responsible Party_____ Date of Birth _____

Emergency Contact _____ Phone # ( )_____

(EMPLOYMENT INFORMATION)

Patient's Employer _____ Work Phone ( )_____

Spouse's Name _____ Spouse's Employer _____

(PRIMARY DENTAL INSURANCE)

Policy Holder's Name _____Policy Holder's Date of Birth _____

Patients relationship to policy holder ( )Self ( ) Spouse ( ) Child ( )Other

Dental Insurance Company _____ Provider Phone # ( )_____

Policy holder Member ID or Social Security # _____ Group #_____

(SECONDARY DENTAL INSURANCE)

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Patients relationship to policy holder ( )Self ( ) Spouse ( ) Child ( )Other

Dental Insurance Company _____ Provider Phone # ( )_____

Policy holder Member ID or Social Security # _____ Group #_____

(METHOD OF PAYMENT)

( ) Cash ( ) Check ( ) Credit/Debit Card ( ) Care credit

PLEASE READ BELOW

Payment in full/out of pocket is expected at your appointment. Payment plans must be arranged prior to treatment and may not exceed 3 months. We will file your insurance claim for you--- filing insurance claims is a courtesy; you are expected to know your benefits. If insurance does not pay your bill, including what we estimated, we will not be responsible for collecting from you insurance company--- but you will need to pay your estimated out-of-pocket portion on the day of service. You are personally responsible for payment of all dental services.