ENDODONTICS OF COLORADO, L.L.C.

Member 2010
ADA American Dental Association®
ADA Recognized Specialty
Endodontics

Today's Date:	

NEW PATIENT INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		**Age:**	
Marital status:	☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed		**SSN:**			
Address:		**Home Phone:**				
		Cell Phone:				
		Email Address:				
Dentist:		**Referred By:**				
Physician:		**Physician Phone:**				
Reason for Being Referred to Our Office:						

PATIENT EMPLOYMENT/SCHOOL

Employer/School Name:		**Status:**	☐Full Time ☐Part Time
Address:		**Work Phone:**	

EMERGENCY CONTACT

Name:		**Relationship:**		**Phone:**	

INSURED PARTY/RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name:		**Employer:**	
Address:		**Employer Address:**	
Phone:		**Relation to Insured:**	☐Self ☐Spouse ☐Child ☐Other
SSN/ID:		**DOB:**	

PRIMARY DENTAL INSURANCE CARRIER		SECONDARY DENTAL INSURANCE CARRIER	
Name:		**Name:**	
Address:		**Address:**	
Phone:		**Phone:**	
Group No:		**Group No:**	
Group Name:		**Group Name:**	

Fees and Payments:
Upon your request, an estimate will be quoted to you based on the complexity of treatment after a complete endodontic evaluation and prior to starting any treatment. Payment is due at time of service. If you have any questions, please ask. I authorize the dentist to release any information including the diagnosis and the records of any examination or treatment rendered to me during the period of such dental care to third party payers and/or other health practices. I authorize a report to be sent to my (family) dentist following each important visit and that I must return to my (family) dentist for a permanent restoration after the root canal is completed. I authorize my insurance carrier to pay any dental benefits on my plan directly to this office. I agree to be responsible for payment of all services rendered on my behalf or my dependent. If the account is referred to an attorney, or suit filed to collect any sum I owe, I agree to pay cost, collection of charges, and reasonable attorney fees.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. It is your responsibility to pay any deductable amount co-insurance or any other balance not paid by your insurance company.

Signature: ______________________________ Date: ______________________