CAROLINA ENDODONTIC ASSOCIATES

PATIENT INFORMATION SHEET

Date _____

Name: Last _____ First _____ MI _____

Mailing Address _____ Email _____

City _____ State _____ Zip Code _____

Cell # _____ Home # _____ Work # _____

DOB _____ Driver's License # _____ SSN _____

Patient Employed by _____ Occupation _____

Pharmacy _____ Referred by (Dentist's Name) _____

Person to contact in Case of Emergency _____

Phone _____ Relationship _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT OR IF PATIENT IS A MINOR:

Name _____ SSN _____ DOB _____ Phone _____

Address _____

Employer _____ Phone _____

PLEASE READ, SIGN AND DATE THE BELOW STATEMENT:

Payment is due at the end of each appointment. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance, as a courtesy we will file your claim for you, but please complete the required information below.

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 others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.** Any unpaid claim over 45 days old is your responsibility. Any unpaid balance will be turned over to collections. I agree to accept texts and emails from Carolina Endodontic Associates. Further, this signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Carolina Endodontic Associates of the benefits otherwise payable to me.

I will be paying today with ☐ Cash ☐ Check ☐ Credit/Debit Card

X _____ _____

Signature of Patient (Parent or Guardian if Minor) **Date**

DENTAL INSURANCE INFORMATION

Primary Insurance

Policy Holder _____ Relation _____

Sex: ☐ M ☐ F DOB _____

SSN _____

Address: Street _____

City _____ State ____ Zip _____

Phone _____

Insurance Company _____

Employer _____

Group # _____

ID # _____

Secondary Insurance

Policy Holder _____ Relation _____

Sex: ☐ M ☐ F DOB _____

SSN _____

Address: Street _____

City _____ State ____ Zip _____

Phone _____

Insurance Company _____

Employer _____

Group # _____

ID # _____