Hill Country Endodontics

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

ADULT PATIENT

NAME		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL NO.	
OCCUPATION	EMAIL	
EMPLOYER	PHONE NO.	
BIRTHDATE	AGE	SEX
SOCIAL SECURITY NO.		
SPOUSE	OCCUPATION	

INSURANCE AND PAYMENT INFORMATION

NAME OF SUBSCRIBER	DOB
ADDRESS (if different from patient)	
SOCIAL SECURITY NO.	DRIVERS LICENSE NO.
RELATIONSHIP TO PATIENT	
EMPLOYER	PHONE NO.
INSURANCE NAME	
INSURANCE PHONE NO.	

CHILD PATIENT

NAME		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.		
BIRTHDATE	AGE	SEX

EMERGENCY CONTACT

PERSON TO CONTACT FOR EMERGENCY		
RELATIONSHIP		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

BE ADVISED 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 FOR BY YOUR INSURANCE COMPANY.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature _____ Date _____

All signatures must be by parent or guardian if patient is under the age of 18