Endodontic Associates of Greater Waterbury

PATIENT INFORMATION

Welcome to our office.
Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be happy to help you.

Mr /Ms / Mrs ____
(Last Name) (First Name) (MI)

Street ____________________ City ____________________ State ______ Zip ________

Home # ( ) ______________ Cell # ( ) ______________ Work # ( ) ______________

Email ______________________________ DOB ____________________

Occupation ______________ Employed by ______________________________

Spouse ______________ Employed by ______________ Phone ( ) ______________

Notify in case of emergency ______________________ Phone ( ) ______________

Your general dentist ____

PRIMARY DENTAL INSURANCE
Carrier ______________________ Group # ______________________

Subscriber ______________________ ID#/SS# ______________ DOB ________

SECONDARY DENTAL INSURANCE
Carrier ______________________ Group # ______________________

Subscriber ______________________ ID#/SS# ______________ DOB ________

Today I will be paying by (please circle one) Cash Check Credit Card

AUTHORIZATION

I authorize the insurance companies listed above to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that REGARDLESS what my insurance pays, I am financially responsible for this account and I have read the Financial Policy on the back of this form.

Signature ______________________________ **Date** ______________

Please print name ____