PATIENT INFORMATION

The following information is for our records only and will be kept confidential.

Date: ____________________ SSN: ______________________________________

Name: __________________________________ Date of Birth: _______/ _______/ __________

Marital Status: ___Single ___ Married ___ Widowed ___ Divorced

Home Address: ____

Town: ______________________________ State: ___ ___ Zip Code: _________________

Home Phone: ( ) ___________________ Cell Phone: ( ) ________________________

Email: __________________________________ Occupation: _____________________________

Employer: _______________________________ Phone: ( ) _______________________

Business Address: ____

Town: _________________________ State: ___ ___ Zip Code: ________________________

If patient is a minor, legal guardian's name: ____

Name of Physician: ____________________________ Phone ( ) ______________________

Emergency Contact: ____________________________ Phone ( ) ______________________

Referring Dentist: ______________________________ Phone ( ) ______________________

Who is financially responsible for this bill? ____

Dental Insurance Information

Primary Dental Coverage	**Secondary Dental Coverage**
Insurance Carrier: ________________________________	Insurance Carrier: _______________________________
Policy Holder's Name: ___________________________	Policy Holder's Name: ___________________________
Policy Holder's ID Number: ______________________	Policy Holder's ID Number: _______________________
Policy Holder's DOB: ____________________________	Policy Holder's DOB: ____________________________
Group Number: ___________________________________	Group Number: ___________________________________
Claim's Address: ________________________________	Claim's Address: ________________________________
Claim's Phone Number: ___________________________	Claim's Phone Number: ___________________________

For your convenience, Endodontic Associates in Framingham, PC and Weston Endodontics, LLC will submit your claim to insurance. I understand that any remaining balance after notification from insurance is my responsibility, and is due in full upon receipt of statement.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts.

Signature: _____________________________________ Date: ____

PLEASE CONTINUE ON OTHER SIDE →