RED ROCKS ENDODONTICS LLC

PATIENT INFORMATION

DATE _____

NAME _____
LAST FIRST M

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTH DATE _____ **TELEPHONE** _____
MONTH DAY YEAR HOME # WORK # CELL #

PLACE OF EMPLOYMENT _____ **SS#** _____

IF FULL TIME STUDENT, SCHOOL NAME _____ **GRADE** _____

Has any member of your family ever been treated in our office? **( ) YES ( ) NO**

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION

****To process insurance claims, SS#'s are required unless an alternate ID# is given by your insurance company.**

PRIMARY INSURED IF INSURANCE COMPLETE FOR RESPONSIBLE PARTY	**SECONDARY INSURED** IF APPLICABLE
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME# WORK#	HOME# WORK#
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INSURANCE CO.	EMPLOYER DENTAL INSURANCE CO.
SS# SUBSCRIBER# GROUP#	SS# SUBSCRIBER# GROUP#

AUTHORIZATION

I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Red Rocks Endodontics LLC office. I understand that I am responsible for all costs of dental treatment, regardless of dental insurance reimbursement. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals as deemed necessary to perform treatment, payment, and/or healthcare operations by Red Rocks Endodontics LLC, and the staff.

METHOD OF PAYMENT

( ) Payment in full (cash or personal check)
( ) Payment in full ( ) VISA ( ) MC
( ) DISCOVER ( ) CARE CREDIT
( ) AMERICAN EXPRESS

PERSON RESPONSIBLE FOR ACCOUNT

(Please check one)
( ) Patient ( ) Father (or husband)
( ) Mother (or wife) ( ) Guardian

X _____ _____
Signature of patient or responsible party *Date*