Central Carolina
ENDODONTICS, P.A.

PATIENT INFORMATION

Full Name _____ Today's Date _____ Sex _____

Marital Status _____ Birthdate _____ Age _____

SS# _____

Address _____ City _____ Zip _____
(For Billing purposes)

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Person financially responsible for account _____

Address & phone if different from the above information _____

_____

Spouse's Name _____ Employer _____

Work Phone _____

In case of emergency, notify _____

Phone _____ Relationship to Patient _____

Family Dentist _____ Family Physician_____

Pharmacy Name_____ Phone Number _____

Pharmacy Address_____

I will be paying today by: □ Cash □ Check □ Debit □ Credit □ Care Credit

(We accept Visa, Mastercard, Discover and American Express)

DENTAL INSURANCE INFORMATION

(Please do not list medical insurance. We can only file **DENTAL** insurance.)

Primary Insurance Co. _____ Name of Subscriber _____

Subscriber DOB _____ Subscriber ID# or SSN _____

If the patient is covered by secondary **DENTAL** insurance, please complete below.

Secondary Insurance Co. _____ Name of Subscriber _____

Subscriber DOB _____ Subscriber ID# or SSN _____

PLEASE COMPLETE FRONT AND BACK OF FORM AND ALL PAPERWORK ON CLIPBOARD