Central Carolina ENDODONTICS, P.A.

PATIENT INFORMATION

Today's Date: _____

Full Name _____ Birthdate _____ Age _____ Sex ____

Marital Status _____ SS# _____ Email: _____

Address _____ Apt. #: _____ City _____ Zip _____
(For Billing purposes)

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Family Dentist _____ Family Physician_____

Pharmacy Name_____ Pharmacy Phone Number _____

Pharmacy Address_____

Spouse's Name _____ Spouse's Phone Number: _____

Person financially responsible for account (If the patient is under 18, please list all legal guardians and contact info)

_____

Address & phone if different from the above information _____

_____

In case of emergency, notify _____

Phone _____ Relationship to Patient _____

I will be paying today by: □ Cash □ Check □ Debit □ Credit □ Care Credit
(We accept Visa, Mastercard, Discover and American Express)

I understand that there will be a 3% convenience fee added to all credit card transactions, which will be **in addition** to the amount I was quoted for services rendered. (Please sign) _____

DENTAL INSURANCE INFORMATION (Please provide insurance card to Receptionist)

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

Primary Insurance Policy _____ Name of Policyholder _____

Policyholder DOB _____ Policyholder ID# or SSN _____ Group #: _____

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

Secondary Insurance Policy _____ Name of Policyholder _____

Policyholder DOB _____ Policyholder ID# or SSN _____ Group #: _____

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