Patient Information

Submit by Email | Print Form

Title: First Name: MI: Last Name:

Date of Birth SSN: Gender: ☐ Male ☐ Female

Address: Apt/Suite:

City: State: Zip Code:

Phones: Home: Work: Fax:

Mobile: Email:

Employer: Employer's phone: Occupation:

Referred by: General Dentist:

Have you ever been a patient in our clinic before? Y N

Person Responsible for the account (if other than patient)

Title: First Name: MI: Last Name: SSN:

Relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Other - Please specify

Address: Apt/Suite:

City: State: Zip Code:

Phones: Home: Work: Fax:

Mobile: Email:

Employer: Employer's phone: Occupation:

Dental Insurance Information

Primary Insurance

Insurance Company

Group #: Phone:

Employer

Employee (if other than the patient)

Name:

Date of birth: SSN:

Subscriber #: Gender: ☐ Male ☐ Female

Secondary Insurance

Insurance Company

Group #: Phone:

Employer

Employee (if other than the patient)

Name:

Date of birth: SSN:

Subscriber #: Gender: ☐ Male ☐ Female

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Greenville Endodontics and its employees to release any information to the Insurance company for any oral or dental observation, treatment, services and/or benefits rendered The information above is true to the best of my knowledge. I will not hold Greenville Endodontics or any other employee, including dentists and other staff, of Greenville Endodontics responsible for any errors and/or omissions that I may have made in the completion of this form and any consequences of such error and/omissions.

Signature of patient (parent or guardian if patient is a minor) Date