Name: _____ Phone: Hm_____-_____-_____
Last First M.I. Wk _____-_____-_____
Address: _____Cell _____-_____-_____

City: _____ State_____ Zip Code_____

Birth Date ____/_____/_____ Age: _____ Gender: M_____F_____

Employer: _____Patient E-mail:_____
Referring Dentist: _____General Dentist:_____
TX Drivers License # _____Patients SS#: _____-_____-_____
Emergency Contact: _____Phone #: ____-_____-_____

FOR MINORS/DEPENDENT, PLEASE PROVIDE:
Parent Name: _____AND Contact#: _____-_____-_____
Guardian Name: _____AND Contact #: _____-_____-_____

DENTAL INSURANCE INFORMATION

Employee: _____ Members SS#: _____-_____-_____
Last First M.I. Members ID #: _____

Phone: (Hm) ____-_____-_____ (wk) ____-_____-_____ Member Date of Birth ___/___/___

Employer: _____

Insurance Co. _____ Phone#: _____ Group#: _____

*****If you have secondary insurance coverage please let us know!!*****

PLEASE COMPLETE AND SIGN INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have dental insurance coverage and assign directly to Woodlands Endodontics, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ ___/___/___
Responsible Party Signature Relationship Date

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS _____.