PATIENT INFORMATION

Name____________________________________Home Phone____________
Address__________________________________City__________________
SS#___________________________Birthdate____________ Zip____________

Spouse's Name________________________Your Work Tel.___________
Nearest relative not living with you
____ Phone___________________

Physician________________________________Phone___________________
Dentist__________________________________Phone___________________
If not referred by dentist, who referred you?____________________________

Who is financially responsible for this bill?____________________________
Address__________________________________Phone____________________
Occupation____
Employer________________________________Phone____________________
Employer's Address____

Payment must be made ***BEFORE*** services are completed.
Paying by Cash_______Check_____Credit Card_______

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that only the root canal is to be at this office. The permanent (outside) restoration will be done by my regular dentist.

____Date_____________
Signature

____Date_____________
Parent (if minor)