Forest Hill ENDODONTICS

PATIENT INFORMATION

Patient Name:_____Salutation (circle):Ms/Mrs/Mr/Dr

Mailing address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Phone:*Cell:*_____*Home:*_____*Work:*_____

Email address:_____ Social Security #_____

Gender: ☐Male ☐Female Date of Birth:_____

Employer:_____

What is your preferred method of contact: ☐cell phone ☐home phone ☐work phone☐e-mail☐text

Person responsible for account:_____Relationship:_____

Referring dentist_____

Dental Insurance

Primary Dental Plan:_____ Member ID or SS#_____

Primary Subscriber: _____ Date of birth: _____

Relationship to patient: _____ Employer: _____

Secondary Dental Plan: _____ Member ID or SS#_____

Secondary Subscriber:_____ Date of birth:_____

Relationship to patient:_____ Employer:_____

Emergency contact

Name:_____ Relationship:_____

Phone#:_____

Signature of patient, parent or guardian:_____

Date:_____