PATIENT INFORMATION
CONFIDENTIAL

Title: Dr. / Mr. / Mrs. / Ms. / Miss Today's Date:_____

NAME:_____ Soc. Sec #_____ Birthdate:_____
first mi last

Address:_____
and street city / state / zip

Home Tel: (_____)_____ Cell: (_____)_____Work Tel:(_____)_____

Employer:_____Occupation:_____

Name of General Dentist who referred you:_____

If the patient is a minor who is the parent or guardian?

Parent / Guardian Name:_____Birthdate:_____Relationship:_____

Address (if different from above):_____
and street city / state / zip

Home Tel: (_____)_____ Cell: (_____)_____Work Tel: (_____)_____

Employer:_____Occupation:_____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name:_____ Telephone #: (_____)_____

Claims Mailing Address:_____
P.O. Box / # and street city/state/zip

Subscriber# / Policy#:_____Group#/Plan#:_____

Primary Policy Holder's Employer:_____

Primary Policy Holder's Name:_____Soc. Sec#:_____

Primary Policy Holder's Birthdate:_____ Relationship to patient:_____

PLEASE READ, SIGN AND DATE BELOW

Release & Agreement to Pay for Services Rendered

I acknowledge Exeter Endodontics is only a participating provider of Northeast Delta Dental Premier insurance company and I understand Exeter Endodontics will bill my private dental insurance as a courtesy to me. I understand this does not constitute an agreement or participation with my insurance company. Should my private dental insurance not pay on my claim within 45days, the account balance will be transferred to me and I will be responsible for full payment of my account within14 days. I will then need to seek reimbursement from my private insurance company on my own. I agree to pay all estimated portions due on the day services are rendered by cash, Visa, MasterCard, Discover, or Care Credit Financial. I understand my dental insurance carrier may pay less than the actual bill for services and it is my responsibility to know and understand my dental insurance benefits. I agree I am responsible for any and all balances not covered by my private dental insurance company for all services rendered on my behalf or on behalf of my dependents.

Patient Signature: _____ Date: _____

Parent ***or*** Guardian Signature if applicable:_____