Eastern Idaho Endodontics PATIENT INFORMATION

The following information is necessary for proper treatment & will be kept confidential

(Mr-Mrs-Ms-Miss-Dr) First: ____________________________ Last: _________________________________ MI: _______

Mailing Address: ____

City: ____ State: _____________ Zip: ____________________________

Cell Phone: ____ Alt Phone:____

Birthdate: _______________________________ ☐Male ☐ Female SSN: ______________________________________

Emergency Contact: ____

Phone: ___________________________________ Relationship to patient: _______________________________________

Name of Referring Dentist: ____

INSURANCE INFORMATION

Please give receptionist your card to copy (If you have secondary insurance, please give receptionist your card)

Policy Holder's Name: ____

Relationship to patient: ______________________________ DOB: __________________ ID#: _____________________

Insurance Company: ____Group #: _________________________

Person responsible for account/finances: ____

*HIPAA-PRIVACY PRACTICES:

I am aware of the Notice of Privacy Practices & I was provided an opportunity to review it. INITIAL: ___________

ALL INFORMATION WRITTEN IS TRUE & COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: ____ DATE: ______________________________