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: _____

IF YOU LIVE IN JACKSON WY YOUR PO BOX IS REQUIRED

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: _____