

Rocky Mountain Endodontics

Patient Information Sheet

I prefer to be called: _____

Name _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Home Phone # _____

Work Phone# _____

Cell Phone # _____

EMAIL: _____

What is your preferred method of contact?

Phone Text Email

Social Security#: _____

Birth Day: _____ Age: _____

Employer: _____

Occupation: _____

Address: _____

City: _____ State _____ Zip: _____

General Dentist Name: _____

Who referred you to us? _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

*Preferred Pharmacy: _____

Insurance submission is offered as a courtesy. Regardless of insurance coverage, the balance of your account is your responsibility. If you would like our office to submit your insurance claim on your behalf, please complete the following:

Primary Dental Insurance Information

Policy Holder: _____ DOB: _____

Circle One: [Self/Spouse/Parent/Other]

Employer _____

SSN or ID # _____ Group # _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Dental Insurance Information

Policy Holder: _____ DOB: _____

Circle One: [Self/Spouse/Parent/Other]

Employer _____

SSN or ID # _____ Group # _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

MY ACCOUNT BALANCE WILL BE PAID FOR BY:

CASH/DEBIT CHECK CREDIT CARD

THIRD PARTY FINANCING

Acknowledgement of Notice of Privacy Practices

My signature certifies that I have reviewed a copy of this office's Notice of Privacy Practices (HIPAA)

If you wish to receive a copy of our notice of Privacy Practices, please check here

Signature (Patient / Guardian) _____

The information I have provided above is true and correct to the best of my knowledge.

*Patient's Signature _____ Date: _____