Rocky Mountain Endodontics

Patient Information Sheet

Nickname:______________________________________

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:** ___________________________

MY ACCOUNT BALANCE WILL BE PAID FOR BY:

[ ] DEBIT [ ] CHECK [ ] CREDIT CARD/HSA

[ ] THIRD PARTY FINANCING

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:__________

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 [ ]

If you wish to opt out of emails, please check here [ ]

By Signing Below, You consent to our *Office's Notice of Privacy Policies,*
and email campaigns to help with quality control.

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

***Patient's Signature**_______________________________**Date:**_____________