Kirkland Endodontics

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Patient Confidential Information

First Name ________________________________ MI _____ Last Name ____________________ Nickname __________

* If Patient is a minor,
Responsible party______________________________ Relationship ______________Contact #____________________

Billing Address________________________________ City ______________________ State ____ Zip Code ___________

Home Phone ________________________ Cell Phone_________________________ Work Phone ___________________

Email ____

Employer ____ Occupation _____________________________

Patient's Birth date Month ________ Day__________ Year___________ Social Security #____________________________

Check Appropriate Box: Minor ________ Single _________Married ________ Divorced _________Widowed ___________

Spouse ____________________________ Employer _____________________ Occupation ______________________

Emergency Contact Name ____ Phone ____________________________

Referring Dentist ____ How long have you been their patient? _________

Your Estimated Portion is Due Upon Completion of Services,

How would you like to pay for today's visit? ____ (Cash, Credit Card etc…)

You Are Financially Responsible for Any Services at This Office

As a courtesy to our patients we are happy to file your Insurance Claim. PLEASE REMEMBER THAT THE INSURANCE CONTRACT IS BETWEEN YOU AND YOUR INSURANCE CARRIER. Assignment & Release: I authorize the dentist or insurance company to release information required for payment or review of this treatment. I authorize payment of benefits, otherwise payable to me to be paid directly to the dentist.

Signature of patient (or guardian) ____ Date _________________

Insurance Information

Primary Dental Insurance ____ Group ______________

Name of Insured ____ Relationship to Patient _______________________

Insured's Birth Date Month ________ Day__________ Year__________ SS# or Id# ____________________________________

Insured's Employer ____ Ins. Co Phone ________________________

Ins. Co. Address ____ City ___________________ St ______ Zip ____________

Secondary Insurance Information

Secondary Dental Insurance ____Group______________

Name of Insured ____ Relationship to Patient _______________________

Insured's Birth date Month ________ Day__________ Year__________ SS# or Id# ___________________________________

Insured's Employer ____ Ins. Co Phone ________________________

Ins. Co Address ____ City _______________________ St ______ Zip __________