Endodontic Associates of Greater Waterbury

PATIENT INFORMATION

Welcome to our office.
Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be happy to help you.

Mr /Ms / Mrs _____
(Last Name) (First Name) (MI)

Street _____ City _____ State_____ Zip_____

Home # ( ) _____ Cell # ( )_____ Work # ( )_____

Soc Sec # _____ DOB _____

Occupation _____ Employed by _____

Spouse _____Employed by _____ Phone ( ) _____

Notify in case of emergency_____ Phone ( ) _____

Your general dentist _____

PRIMARY DENTAL INSURANCE
Carrier _____ Group # _____

Subscriber _____ Soc Sec # _____ DOB _____

SECONDARY DENTAL INSURANCE
Carrier _____ Group # _____

Subscriber _____Soc Sec # _____ DOB _____

Today I will be paying by (please circle one) Cash Check Credit Card

AUTHORIZATION

I authorize the insurance companies listed above to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that REGARDLESS what my insurance pays, I am financially responsible for this account.

Signature _____ **Date** _____

Please print name _____