Coastal Endodontics
Kimberly S. Long, D.D.S., P.A.

Patient Registration Date_____

Name_____Sex: ☐ Male ☐ Female

Birth Date_____Check One ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Phone_____Cell Phone_____

Address_____City_____State _____Zip_____

Social Security #_____Driver's License_____

Employer_____Work Phone_____

Spouse's Name_____Work Phone_____

Referring Dentist_____ General Dentist_____

Dental Insurance Company (Primary)_____Plan_____

Group #_____ID #_____

Dental Insurance Company (Secondary) _____Plan_____

Group #_____ ID #_____

Responsible Party (if other than patient or if patient is a dependent)

Name_____Relationship to Patient_____

Birth Date_____Social Security #_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Consent for Consultation and Payment

I consent to receive endodontic consultation which may involve diagnostic x-rays, testing the condition of the teeth, and examination of surrounding tissues. I understand that if endodontic treatment is needed, the treatment may consist of more than one appointment requiring several x-rays and administration of a local anesthetic.

I also understand that only root canal treatment will be performed at this office, and I am to return to my regular dentist for permanent restoration (filling, crown, etc.) of the treated tooth / teeth.

Payment in full is expected at the time of treatment. If you have dental insurance, our office will file an insurance claim for dental services rendered.

I acknowledge full responsibility for the payment for professional services rendered.

Method of payment: ☐ Cash ☐ Visa ☐ MasterCard ☐ Check ☐ Care Credit

_____Date_____

Signature of Patient (Parent if Patient is a Minor)