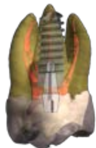

Endodontic Microsurgical Innovations

Welcome, and thank you for selecting our office for your CBCT scan.

Please complete this form in ink. If you have any questions or need assistance, please ask and we will be happy to help.

Patient Information (Confidential)

Name____Date______________

Soc. Sec. #____________________________Birthdate__________Home Phone___________

E-mail________________________________ Cell Phone____________________

Address____________________________City_____________State________Zip________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College__________________City________State________FT/PT?______

Patients/Parents Employer____________________________________Work Phone___________

Business Address______________________________City________State________Zip________

Spouse/Parents Name_________________Employer_______________Work Phone___________

Referring Doctors name: ______________________________ Region: ____________________

CBCT scan: Mailed to Dr. ________ Given to patient ________ Other ________

Responsible Party

Name of Person Responsible for this Account_________________________Relationship to Patient___________

Address____Home/Work Phone_____________

Insurance Information

Name of Person Responsible for this Account_________________________Relationship to Patient___________

Birthdate___________Soc.Sec. #______________________________Date Employed___________

Name of Employer__________________________Union/Local #________Work Phone___________

Employer Address__________________________City_____________State________Zip________

Insurance Company_________________________Group #__________Policy/ID#____________

Ins. Co. Address__________________________City_____________State________Zip________

Do You Have Additional Insurance? ☐ Yes ☐ No *If Yes, complete the following*

Name of Person Responsible for this Account____

Birthdate___________Soc.Sec. #______________________________Date Employed___________

Name of Employer__________________________Union/Local #________Work Phone___________

Employer Address__________________________City_____________State________Zip________

Insurance Company_________________________Group #__________Policy/ID#____________

Ins. Co. Address__________________________City_____________State________Zip________