EXPERT ENDODONTICS

The Root Canal Specialists

New Patient Registration

"To help us provide you with the best care, please fill out the medical history form below to the best of your ability. Don't hesitate to ask our front desk team if you need any clarification or have any questions."

Patient Name:_____ DOB:_____
SSN:_____
Phone: Primary: _____Secondary _____E-mail: _____
Mailing Address:_____
_____
Street City State Zip
If Patient is a Minor, Who is Accompanying the Patient Today? _____ Legal Guardian ☐ YES ☐NO
Employer: _____ Occupation: _____ How long? _____
Employer's Address:
_____
Street City State Zip
Whom may we thank for referring you?_____
Who is your General Dentist?
_____
Emergency Contact Name: _____Contact Phone: _____
Are there any special dental considerations that we should be aware of? ☐YES ☐NO
Please Explain:
_____
_____

Dental Insurance Information

Insurance Company Name: _____ Phone Number: _____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's DOB: _____ Subscriber's SSN: _____
Subscriber's Employer: _____ Employment Date _____ Work Phone: _____
Subscibers ID#:_____Group #: _____

Secondary Dental Insurance Information (If Applicable)

Insurance Company Name: _____ Phone Number: _____

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The Root Canal Specialists

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's SSN: _____

Subscriber's Employer: _____ Employment Date _____ Work Phone: _____

Subscibers ID#:_____Group #: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Relationship to Patient: _____

Address:_____

_____

Street City State Zip

Home Phone: _____Alternate Phone: _____Email: _____

DOB: _____SSN#_____ Driver's license #_____

Employer: _____Work Phone: _____

PATIENT/LEGAL GUARDIAN SIGNATURE: _____DATE: _____