Eastern Idaho Endodontics
PATIENT INFORMATION

The following information is necessary for proper treatment & will be kept confidential

(Mr-Mrs-Ms-Miss-Dr) First: _____ Last: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Alt Phone:_____

Birthdate: _____ ☐Male ☐ Female SSN: _____

Emergency Contact: _____

Phone: _____ Relationship to patient: _____

Name of Referring Dentist: _____

INSURANCE INFORMATION

Please give receptionist your card to copy (If you have secondary insurance, please give receptionist your card)

Policy Holder's Name: _____

Relationship to patient: _____ DOB: _____ ID#: _____

Insurance Company: _____Group #: _____

Person responsible for account/finances: _____

FINANCIAL AGREEMENT

PAYMENT IS DUE AT THE TIME OF SERVICE. FOR PATIENTS WITH DENTAL INSURANCE, A CLAIM WILL BE FILED ON THEIR BEHALF. FINANCE CHARGES ARE ASSESSED 90 DAYS [AFTER THE INSURANCE PAYS] ON ANY REMAINING BALANCE.

Patients with dental insurance pay *estimated* portion at time of visit. All insurance quotes are estimates and not a guarantee of payment. Actual payment will depend on the plan provisions in effect at the time of service and receipt of claim. Any difference of payment leftover after insurance is solely the responsibility of the patient/responsible party.

I further authorize my insurance company and/or benefits administrator to pay these assigned benefits directly to Eastern Idaho Endodontics. I understand I am financially responsible for any charges, whether or not paid by my insurance and/or benefits administrator, and that Eastern Idaho will submit billings to my insurance company and/or benefits administrator as a courtesy for me. Unpaid balances may be subject to referral to a collection agency for further debt resolution.

*HIPAA-PRIVACY PRACTICES:

I am aware of the Notice of Privacy Practices & I was provided an opportunity to review it. INITIAL: _____

ALL INFORMATION WRITTEN IS TRUE & COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____