SAN CLEMENTE ENDODONTICS

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A COMPLETE CONFIDENTIAL RECORD IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Circle One: Miss Mrs. Ms. Mr. Dr. Child **Sex:** M F Single Married Widow **Age**: _____

Name: (last) _____(first) _____(middle) _____ **Date of Birth:** _____

Address: _____ **Dvr License#:** _____ **State:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____)_____ **Work Phone:** (_____)_____**Cell Phone:** (_____)_____

Employer: _____ **Social Security No:** _____

In case of emergency notify: (other than spouse) **Name:** _____**Phone:** _____

Patient's Dentist: _____City _____Patients Physician _____City_____

Referred by:

INSURANCE

If you wish to have us bill your insurance company, please provide the receptionist with your insurance information!

Whose Policy Provides Coverage? Self ____ Spouse ____ Parent_____ **Name of Policy Holder:**_____

Insurance Company Name: _____ **Group Number:** _____ **Insurance ID Number:** _____

Policy Holder's Employer: _____ **Policy Holder's SSN:** _____ **DOB:**_____

Secondary Insurance Company (if any): _____ **Group Number:** _____ **ID:** _____

Policy Holder Name: _____ **Employer:** _____ **SSN:** _____ **DOB:**_____

PAYMENT AGREEMENT

FULL PAYMENT OR CO-PAYMENT IS DUE AT THE TIME TREATMENT IS INITIATED.

I will be paying for services today by: **Cash:** ☐ **Check:** ☐ **Credit Card:** ☐

Finance charges shall be assessed upon all unpaid balances more than 30 days past due. The monthly periodic interest rate is 1.5%, the corresponding APR is 18%. I agree to pay for any finance charges or collection fees incurred as a result of any treatment.

My insurance carriers are authorized to issue dental benefits of my plan directly to San Clemente Endodontics and Karen S. Potter DDS, Inc. I authorize release of any information necessary to process my dental insurance.

Patient/Parent Signature:_____ **Date:** _____