Northgate Endodontics P.S.

Patient Information:

First Name: ____________________ Last Name: _______________ Birth Date: _____/______/_______

Address: _________________________________City/State____________________ Zip: ___________

Home Phone___________________ Bus Phone: __________________ Cell Phone: _______________

Email: _______________________________ What is your preferred Contact Method? _______________

Drivers License #: ______________ SS# __________________ Occupation: _____________________

Employer: ______________________ Business Address: _____________________________________

Referring Dentist: ____

General Dentist (If Different): ____

Who to contact in case of an emergency? ______________________________ Phone: ______________

Primary insurance information:

Insurance Company: ________________________ Employer: _________________________________

Subscriber Name: __________________________ Relationship to patient: _______________________

Subscriber DOB: _____________ Member ID #/ SS#__________________ Group # ______________

Secondary insurance information: (if applicable)

Insurance Company: ________________________ Employer: _________________________________

Subscriber Name: __________________________ Relationship to patient: _______________________

Subscriber DOB: _____________ Member ID #/ SS#__________________ Group # ______________

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for this claim.

Patient/Guardian Signature: _________________________________ Date: ______/______/________