PATIENT INFORMATION

NAME: _____ **Male:** ____ **Female:** ____
LAST NAME FIRST NAME INITIAL

DATE OF BIRTH: _____/_____/_____ **SSN:** _____/_____/_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP** _____

CELL: (_____) _____-_____ **EMAIL:** _____

IN CASE OF EMERGENCY, CONTACT: _____

PHONE (_____) _____-_____ **RELATIONSHIP:** _____

DENTAL INSURANCE

INSURANCE COMPANY _____ **ON FILE: YES OR NO**

I AUTHORIZE THE INSURANCE COMPANY TO ISSUE PAYMENT DIRECTLY TO THE DENTIST. I AUTHORIZE THE USE OF THIS SIGNATURE FOR ALL INSURANCE CLAIMS.

WE WILL GLADLY ASSIST YOU IN RECEIVING THE MAXIMUM **OUT OF NETWORK** BENEFITS PROVIDED BY YOUR DENTAL CARRIER. YOU MUST UNDERSTAND THAT THIS IS ONLY AN ESTIMATE. YOU ARE RESPONSIBLE FOR THE FEES CHARGED BY OUR OFFICE, NO MATTER WHAT YOUR INSURANCE COVERAGE MAY BE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES NOT PAID BY THE DENTAL INSURANCE. IF THERE IS A DIFFERENCE AFTER YOUR INSURANCE PAYS, WE WILL EITHER SEND YOU A REFUND OR A BILL FOR THE BALANCE.

Total cost of treatment before insurance is applied:

Evaluation: (with scan)	**$330**	**Fillings**	**$210-230**
Anterior Root Canal	**$1650**	**Anterior Retreatment**	**$1755**
Bicuspid Root Canal	**$1750**	**Bicuspid Retreatment**	**$1855**
Molar Root Canal	**$1850**	**Molar Retreatment**	**$1955**
		Incomplete Endo	**$730**

_____ Date: _____/_____/_____
Patient or Patient's Guardian Signature