Tirrell Endodontics

Bart C. Tirrell, D.D.S., M.S.D., P.S.

Patient Information:

Name: _____ Nickname/Preferred Name: _____

Soc. Sec. #_____ Email Address: _____

Home Phone:_____ Cell Phone: _____

Address:_____City: _____

State: _____ Zip Code: _____ Sex: _____ Birth Date: _____ Age: _____ Marital Status: _____

Employer: _____Occupation:_____ Business Phone:_____

Notify in case of emergency: _____ Relation to Patient:_____

Home Phone: _____ Cell Phone:_____

Who may we thank for referring you?_____

Primary Dental Insurance:

Insurance Company: _____ Phone: _____

Person Responsible for Account: _____Relation to Patient: _____ Birth date: _____

Soc. Sec. #: _____ ID#_____ Group#: _____

Employed by: _____ Occupation: _____ Business Phone: _____

Additional Dental Insurance:

Insurance Company: _____ Phone: _____

Person Responsible for Account: _____Relation to Patient: _____ Birth date: _____

Soc. Sec. #: _____ ID#_____ Group#: _____

Employed by: _____ Occupation: _____ Business Phone: _____

Method of Payment:

All information is true and correct. If the account is placed with an attorney and/or collection agency all reasonable costs and/or legal fees shall be the responsibility of the undersigned. If dental insurance applies, although this office files insurance claims as a courtesy, the insurance contracts between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.

Signature: _____ Date: _____