West Seattle Endodontics

5016 California Ave. SW Seattle, WA 98136 206-937-1010

Patient Information

Patient Name:_______________________________________ Date: _______________________
Address: ____ Apt #: ___________________
City: _________________________ State: _________ Zip: _______________
Phone (home): (____)_____-__________ Phone (cell): (____)_____-__________
Birthdate: __________________ SS#: ______-_____-________ Gender: _________
Occupation: ___________________________________ Single/Married/Widowed/Divorced
(parent's if minor) (circle one)

Employer: _________________________________ Phone (work): (____)_____-__________
Employer Address: ____
City: _________________________ State: _________ Zip: _______________

Person Responsible for payment: ____
Name of Spouse: ___________________________________
Spouse's Employer: ______________________________ Phone (work):(____)_____-__________
Employer Address: ____

Referring Dentist: ____

If you have Dental Insurance:

Primary Insurance Carrier: ____
Insurance Carrier address: ____
Name of policyholder: ____
Social Security #: ______-_____-________ Group #: ______________________________________
Employer: ____
Secondary Insurance Carrier: ____
Insurance Carrier address: ____
Name of policyholder: ____
Social Security #: ______-_____-________ Group #: ______________________________________
Employer: ____

Payment for services is the responsibility of the patient and is payable by the time treatment is completed. In the event you have dental insurance, we will accept direct assignment of benefits (if such benefit coverages can be pre-determined. We will be happy to assist in the preparation of insurance forms.

Patient Signature: ____ Date: ____________________