PATIENT'S INFORMATION

Patient's Name	Marital Status (S / M / W / D / SEP)	Date of Birth / /	Age	Sex	Social Security #
Street Address	City, State, Zip				
Home Phone #	Cell Phone #	Email			
Patient's Employer	Occupation (Indicate if Student)	How Long Employed	Work Phone #		
Employer's Street Address	City, State, Zip				
Spouse's Name	Spouse's Employer	Occupation	How Long Employed	Cell Phone #	
Spouse's Employer's Street Address	City, State, Zip	Work Phone #			
Referred By:	Street Address	City, State, Zip			
Name of Nearest Relative Not Living at Home	Phone	Relationship to Patient			

IF THE PATIENT IS A MINOR OR STUDENT

Father's Name	Street Address, City, State, Zip		Home Phone #
Father's Employer	Occupation	How Long Employed	Work Phone #
Father's Employer Street Address	City, State, Zip		Cell Phone #
Mother's Name	Street Address, City, State, Zip		Home Phone #
Mother's Employer	Occupation	How Long Employed	Work Phone #
Mother's Employer Street Address	City, State, Zip		Cell Phone #
Person Responsible for Payment, if Not Above	Street Address, City, State, Zip		Home Phone #

INSURANCE INFORMATION

Primary Insurance Co. ____________________________ Subscriber Name ____________________________ Subscriber Birthdate ____ / ____ / ____

Policy ID # ____ Group # ____

Secondary Insurance Co. __________________________ Subscriber Name ____________________________ Subscriber Birthdate ____ / ____ / ____

Policy ID # ____ Group # ____

Gateway Endodontics is a fee for service practice. A patient's portion for treatment is due at the time of service. If insurance information is provided, an estimated copayment will be provided based off of the information collected from your insurance carrier. As a courtesy, our office will file an insurance claim with your carrier for services rendered. Insurance benefits are not a guarantee of coverage and any copayment provided by our practice is an estimate not a guarantee of payment. Gateway Endodontics accepts the following payment methods- cash, check, credit card, and/or CareCredit.

Patient Name: ____ Date: ________________

RICHARD ORRICK, DMD, MSD

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