APEX ENDODONTICS, LLC – Dr. Christopher A. Palmer

PATIENT INFORMATION

Last name:	First Name:		M-I:	❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.
SS#:	Marital status (circle) Single / Mar / Div / Sep	Birth date: / /	Age:	Sex: ❑ M ❑ F
Phone (H):	Ph (W):	Ph (C):		
Street address:				
P.O. box:	City:	State:	ZIP Code:	
Chose office because/Referred to office by (please check):	❑ Dr. _____	❑ Insurance Plan		
❑ Family	❑ Friend	❑ Close to home/work	❑ YellowPages.com	❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Ph #: ( )
Address (if different):		
Employer:	Employer address:	Employer Ph #:

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:		SS#:	Birth date:	
			/ /	
Subscriber ID:		Group #:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):

Subscriber's name:		SS#:	Birth date:	
			/ /	
Subscriber ID:		Group #:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Ph #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Apex Endodontics, LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*