

MILLENNIUM ENDODONTICS

HEALING WITH A GENTLE TOUCH

Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
Last First MI

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____

Street Apartment/Unit #

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Insurance Information

PRIMARY

Name of Subscriber: _____ Is subscriber the patient? Yes No
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____

Address: _____

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insurance Information

SECONDARY

Name of Subscriber: _____ Is subscriber the patient? Yes No

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____

Subscriber's Employer Name: _____

Address: _____

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

In Case Of Emergency:

Name and Phone Number: _____