Kevin Andrus, DDS MS
Randy W. Garland, DDS
LeeAnn Kardosh, DDS

Welcome!

PATIENT INFORMATION — CONFIDENTIAL

NAME: ____________________________
first middle last

Address: ____________________________
street city state zip

Nickname: ________ **Birthdate:** ___/___/___ **S.S. #:** ___-___-___

Contact Information

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ E-mail: ____________

Emergency Contact Information

Name: ____________

Relationship: ____________

Phone Number: ____________

Whom may we thank for referring you? ____________

Patient's or Parent's Employer: ____________ **Occupation:** ____________

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT

Name of person responsible for this account: ____________ **Relationship:** ____________

Address: ____________________________
street city state zip

Phone #: ________ **Birthdate:** ___/___/___ **S.S. #:** ___-___-___

Employer: ____________ **Work Phone:** ____________

Is this person currently a patient in our office?: Yes No

DENTAL INSURANCE INFORMATION

Insurance Company Name: ____________ **Insurance Phone:** ____________

Address: ____________________________
street city state zip

Subscriber's Name (if different from Patient): ____________

Subscriber Birthdate: ___/___/___ **Subscriber S.S. #:** ___-___-___

Group #: ____________ **Policy ID #:** ____________

Secondary Insurance?: **Yes** **No** (If yes, please notify the front desk)

Authorization, Release & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I authorize and hereby request my insurance company to pay directly North County Endodontics insurance benefits otherwise payable to me.

I understand that there is a $10.00 late fee charge per month on account balances of 90 days or more past due. I also understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents. **I also understand that any quote given to me by this office is only an estimate.**

____________________ Signature of patient or parent if minor

____________ Date