"THE ROOT CANAL GUY"

Andrew J. Krygier D.M.D

American Association of Endodontists
Specialist Members

DENTAL TEAM

PATIENT INFORMATION

Name_____ _____
Last First Middle Marital Status

Home Address_____
Street City State Zip

Mailing
Address_____
Street City State Zip

How long at this address?_____ Home Phone # ( )_____ Work Phone # ( )_____
Other Phone # (mobile phone)_____

Social Security #_____ Birth Date_____

Occupation_____ Employer's Name_____

Party Responsible for Payment of Account_____ Phone # ( )_____

Whom may we thank for referring you to our office?_____ _____
General Dentist

DENTAL INSURANCE INFORMATION

Insurance Co. Name:_____ Insurance Co. Phone #_____

Insurance Co. Address:_____ Policy Group #_____

Insured's Name:_____ Soc. Sec. # _____

Insured's Birth Date:_____ Insured's Employer:_____

EMERGENCY INFORMATION

Name of Emergency Contact:_____ _____
Relationship

Complete Address:_____ Phone # ( )_____

METHOD OF PAYMENT

Which of the following methods of payment will you be using? (Fees must be paid **IN FULL** at the completion of treatment)

Method of Payment Cash Check Visa MC AmEx Discover CareCredit

All information written is true and complete. If the account is placed with an attorney and/or collection agency, all reasonable costs and/or legal fees shall be borne by the undersigner. I further understand that a 1.5% finance charge (18% annually) will be added to any balance after the completion of planned treatment. If dental insurance applies, although this office files insurance claims as a courtesy to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.

Signature_____ Date_____

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