Steve Osmond, DDS, MSD
Practice Limited to Endodontics

Medford Endodontics
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PATIENT INFORMATION

Patient Information

Name _____ Birthdate _____ Social Security # _____

Physical Address _____ Apt/Space _____

City _____ State _____ Zip Code _____

Mailing address if different than physical address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Spouse's Name _____ Work Phone _____ Ext _____ Cell _____

Referring Dentist _____ Emergency Contact _____

Primary Dental Insurance *(unless you have a current dental insurance card)*

Subscriber Name _____ Subscriber Birthday _____ Subscriber SS # _____

Subscriber Employer _____ Policy/Member ID # _____

Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip Code _____

Secondary Dental Insurance *(if applicable)*

Subscriber Name _____ Subscriber Birthday _____ Subscriber SS # _____

Subscriber Employer _____ Policy/Member ID # _____

Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip Code _____

Responsible Party *(if not the same as patient)*

Name _____ Relationship to patient _____

Birthdate _____ Phone _____ Work Phone _____

Social Security # _____ Address _____ City _____ Zip _____

Payment is due in full at the time of treatment. We will provide assistance to aid you in obtaining insurance reimbursement; however, you are responsible for all costs of dental treatment. *Your portion is just an estimate and may be lower or higher depending on your insurance fee schedule.* If you want to know exact amount of portion, we can submit a pre-authorization which takes about 3-6 weeks. I understand that I am responsible for all costs of dental treatment. A finance charge will be added to accounts over 30 days past due. Accounts that become delinquent and sent to collections will be assessed a $25 processing fee to be forwarded to collections. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____

Patient or Guardian Signature Date

PLEASE CONTINUE FILLING OUT THE REMAINING FORMS ATTACHED