PATIENT INFORMATION

The following information is for our records only and will be kept "confidential"

Name:_____D.O.B. :_____

S.S.N. :_____Marital: Status: __ Single __ Married __ Widowed __ Divorced

Home Address:_____

Town/City:_____ State:_____ Zip Code:_____

Best phone # to reach you: ( )_____Home phone: ( )_____

Email:_____

Occupation:_____ Employer:_____

Name of Physician: _____ Phone: ( )_____

Emergency Contact:_____ Phone: ( )_____

If patient is a minor, legal guardian's name:_____

Dental Insurance Information:

Primary Insurance Name:_____

Policy holder name:_____

Policy holder D.O.B.: _____

Group number: _____

Subscriber number:_____

Secondary Insurance Name:_____

Policy holder name:_____

Policy holder D.O.B.: _____

Group number: _____

Subscriber number:_____

Metrowest Endodontics "DBA" for, Endodontics Associates in Framingham, P.C. and Weston Endodontics, L.L.C. will submit your claim/s to your insurance company. You understand and agree that any remaining balance after notification from insurance company for your claim/s payment to us is your responsibility. It is due in full upon receipt of account statement.

You also agree to reimburse Metrowest Endodontics of any fees for collection agency, which may be used on a percentage at a maximum of 33% of the debt, all costs and expenses, including reasonable attorneys' fees if we incur in such collection efforts for your debt with us.

Signature: _____ **Date :** _____