

# Cedar Rapids Endodontics, PC

2750 First Ave NE, Suite 410

Welcome! Please read and complete the following materials and do not hesitate to ask if you have any questions. Thank You.

## Patient Registration

Date \_\_\_\_\_

\_\_Mr. \_\_Mrs. \_\_Ms. \_\_Dr.

Birthdate \_\_\_\_\_

\_\_\_\_\_

First

MI

Last

street/mailling address

City

State

Zip Code

Home Phone/Cell Phone

Work Phone

ext

E-mail Address

Social Security Number

sex: M or F

Occupation

Employer's Name

Referring Dentist Name

Medical Doctor's Name

Emergency Contact Name and Phone Number

## Person Responsible for Account if not Patient

First Name

MI

Last

Home Phone

Cell Phone

Work Phone

Street/Mailing Address

City

State

Zip

Relationship to Patient

Date of Birth

Social Security Number

Occupation

Name of Employer

## Insurance Information: Dental Insurance (not health ins.)

**Primary** Insurance Company

Member's First Name

Last Name

Date of Birth

Insurance ID #

Group #

Social Security Number if no ID#

Name Of Employer

**Secondary** Insurance Company

Member's First Name

Last Name

Date of Birth

Insurance ID#

Group #

Social Security Number if no ID#

Name Of Employer