Tirrell Endodontics

Bart C. Tirrell, DDS, MSD
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Patient Information:

Name: _____Preferred Name: _____

Mailing Address:_____City: _____

State: _____ Zip Code: _____ Email Address: _____

Home Phone:_____ Cell Phone: _____Preferred form of Contact_____

Sex: _____ Birth Date: _____ Social Security _____ Age: _____ Marital Status: _____

Employer: _____Occupation:_____ Business Phone:_____

Notify in case of emergency: _____ Relation to Patient:_____

Home Phone: _____ Cell Phone:_____

Who may we thank for referring you?_____

Primary Dental Insurance:

Insurance Company: _____ Phone: _____

Person Responsible for Account: _____Relation to Patient: _____ Birth date: _____

Soc. Sec. #: _____ ID#_____ Group#: _____

Employed by: _____ Occupation: _____ Business Phone: _____

Additional Dental Insurance:

Insurance Company: _____ Phone: _____

Person Responsible for Account: _____Relation to Patient: _____ Birth date: _____

Soc. Sec. #: _____ ID#_____ Group#: _____

Employed by: _____ Occupation: _____ Business Phone: _____

Method of Payment:

All information is true and correct. If the account is placed with an attorney and/or collection agency all reasonable costs and/or legal fees shall be the responsibility of the undersigned. If dental insurance applies, although this office files insurance claims as a courtesy, 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. By providing my contact information: phone, e-mail, address, etc, I expressly consent to receiving communications from the provider(s), its staff, contractors, collection agents and others. These parties may use this information to contact me by live agent, voice mail, text message, using an auto-dialer, pre-recorded message(s), other computer assisted technology or any other form of electronic communication.

Signature: _____ Date: _____