Welcome to our Endodontic Office

Please Print

Female ___ Male___ Date of Birth______________ E-mail address:__________________________________

Name: Last__________________________________ First_________________________ M.I._____________

ADDRESS: Street___________________________________ City____________________ Zip____________

Home Phone #_____________________Work#_____________________ Cell/Other#______________________

S.S.#_____________________________ Oregon Driver's Lic. #______________________________

Referred by:_____________ General Dentist:________________ How long his/her patient?___________________

Personal Physician_____________________________ Telephone#___________________________________

Employer____________________________________ Address____

Occupation__________________________________ Length of employment________________________________

Spouse's Name___________________________________ Work Phone____________________________________

Employer______________________________ Address____

Nearest friend or relative not living with you____

Relationship___________________ Address______________________________Phone_______________________

Primary Dental Insurance

Ins. Co. Name__________________________________ Employer/Group#_________________________________

Ins. Co. Address_________________________________ Customer Service#_______________________________

Subscriber ID________________ Subscriber Name_____________________ Subscribers Date of Birth__________

Secondary Dental Insurance

Ins. Co. Name_____________________________________ Employer/Group#______________________________

Ins. Co. Address__________________________________ Customer Service#_____________________________

Subscriber ID_____________ Subscriber Name_______________________ Subscribers Date of Birth___________

The above information is true and correct to the best of my knowledge; I have read and agree to the policies stated in the "Welcome to Our Endodontic Practice" brochure. I authorize release of information necessary to process insurance and authorize payment of dental insurance benefits directly to Dr. Thomas Barrett. All accounts 60 days and over are subject to a $2.00 monthly billing fee. I acknowledge full responsibility for payment of fees for services. In case of default I agree to pay re-billing fees, collection costs and reasonable attorney fees incurred to effect collection of this account.

Signature ____ Date______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

Please initial: _______Reviewed a copy of Thomas N. Barrett, DMD, MS, PC's Notice of privacy Practices

Print Name:__________________________ Signature___________________________ Date_________