

# Welcome

## Patient Registration

Patient Name: \_\_\_\_\_  
Last First Initial

Patient Date of Birth: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ DL#: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Patient Is:  Policy Holder  
 Responsible Party  
 Minor\*

\*Guardian Information:

Guardian/Parent Name: \_\_\_\_\_

Guardian/Parent Address: \_\_\_\_\_

Guardian/Parent City: \_\_\_\_\_

Guardian/Parent State & Zip: \_\_\_\_\_

Responsible party:

Name: \_\_\_\_\_  
Last First Initial

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Insurance Information:

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insurance Company: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Birth date: \_\_\_\_\_

Insured Address: \_\_\_\_\_

Method of Payment:  Insurance  Cash  Credit Card

Purpose of Call: \_\_\_\_\_

Other Family Members in this Practice: \_\_\_\_\_

Whom may we thank for this referral?: \_\_\_\_\_

Someone to notify in case of emergency not living with you: \_\_\_\_\_

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