EDWARDS
ENDODONTICS

KEVIN R. EDWARDS, DDS, LLC
PRACTICE LIMITED TO ENDODONTICS

Medical Dental Building
833 SW 11th Avenue, #910
Portland, OR 97205

(CONFIDENTIAL INFORMATION FOR OUR RECORDS ONLY) Mr. ☐ Mrs. ☐ Ms. ☐ Other_____

PATIENTS NAME _____

ADDRESS _____

CITY, STATE _____ ZIP _____

BIRTH DATE _____ DRIVERS LICENSE NO. _____ M ☐ F ☐

PHONE #s HM:_____ WK: _____ CELL: _____

NAME OF SPOUSE/PARTNER _____

IF STUDENT, NAME OF PARENT OR GUARDIAN _____

- ADDRESS & PHONE # _____

YOUR DENTIST'S NAME _____ PHONE _____

YOUR PHYSICIAN'S NAME _____ PHONE _____

PATIENT'S EMPLOYER _____ SS# _____

PRESENT POSITION _____

SPOUSE / PARTNER EMPLOYER _____ SS# _____

PRESENT POSITION _____ WORK PHONE: _____

INSURANCE CLAIMS INFORMATION

Dental Insurance is a benefit purchased by or for the patient. We cannot be responsible for what you have purchased. As a courtesy we will fill out and file a claim form for you, but you are responsible for the entire bill. If the information you supply is incomplete or inaccurate, you will be responsible for full payment to our office and filing with your insurance carrier will be your responsibility.

PRIMARY DENTAL CARRIER	SECONDARY DENTAL CARRIER
Insurance Co.	Insurance Co.
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Group or Plan #_____	Group or Plan #_____
Subscriber :_____	Subscriber :_____
Employer: _____	Employer: _____
ID #_____	ID #_____
Date of Birth : _____	Date of Birth : _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. KEVIN R. EDWARDS FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Patient / Parent
Signature_____ Date _____