Welcome to Canyon Ridge Endodontics. Please provide us with all the information requested below. All information is kept confidential

---

PLEASE PRINT

Referring dentist _____ **Today's Date :** _____

PATIENT INFORMATION

Patients LEGAL Name: Last_____ **First**_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Sex: _____ **Age:** _____ **D.O.B.:** _____ **Social Security #:** _____

Legal Guardian's Name (If applicable) _____

INSURANCE INFORMATION: **PLEASE FILL OUT AS BEST AS POSSIBLE**

Primary Dental Insurance Plan: _____ **ID number:** _____

Group #: _____ **Employer:** _____

Relationship to patient: ☐ **self** ☐ **spouse** ☐ **other** **Spouse/ other name** _____ **DOB** _____

****Secondary Dental Insurance:** _____ **ID number** _____

Policy holders Name (secondary insurance) : _____

Group number: _____ **Relationship to patient:** ☐ **self** ☐ **spouse** ☐ **other**

Employer _____ **Spouse/ other name** _____ **DOB** _____