Harry G. Bobotis, D.M.D.
Practice Limited to Endodontics

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Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form to help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient #__________
SS#__________
Date__________

Patient Information (CONFIDENTIAL)

Name__________ Birthdate __________ Home Phone__________
Address__________ City __________ State _____ Zip _____
Email__________ Cell Phone __________
If Student, Name of School/College__________ City __________ State _____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer__________ Work Phone__________
Business Address__________ City __________ State _____ Zip _____
Spouse or Parent/Guardian's Name__________ Employer __________ Work Phone __________
Whom May We Thank for Referring You?__________
Person to Contact in Case of Emergency__________ Phone __________

Responsible Party

Name of Person Responsible for this Account__________ Relationship to Patient __________
Address__________ Home Phone __________
Email __________ Cell Phone __________
Driver's License #__________ Birthdate__________
Employer__________ Work Phone__________ SS# __________
Is this Person Currently a Patient in our Office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment
☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured__________ Relationship to Patient__________
Birthdate__________ SS#__________ Date Employed __________
Name of Employer__________ Work Phone__________
Address of Employer__________ City __________ State_____ Zip _____
Insurance Company__________ Group # __________ Policy/ID #__________
Ins. Co. Address __________ City__________ State_____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured__________ Relationship to Patient__________
Birthdate__________ SS#__________ Date Employed __________
Name of Employer__________ Work Phone__________
Address of Employer__________ City __________ State_____ Zip _____
Insurance Company__________ Group # __________ Policy/ID #__________
Ins. Co. Address __________ City__________ State_____ Zip _____