Coastal Endodontics
Thomas M. Buttke, Ph.D., D.D.S., P.A.

Patient Registration Date____________________

Name____Sex: ☐ Male ☐ Female

Birth Date___________________________Check One ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Phone______________________________Cell Phone_____________________________________

Address____City______________State _______Zip_________

Social Security #____________________________Driver's License__________________________________

Employer____Work Phone____________________

Spouse's Name____Work Phone____________________

Referring Dentist__________________________________ General Dentist___________________________

Dental Insurance Company (Primary)___________________________________Plan_____________________

Group #________________________________ID #____

Dental Insurance Company (Secondary) ________________________________Plan___________________

Group #_______________________________ ID #____

Responsible Party (if other than patient or if patient is a dependent)

Name____Relationship to Patient_______________________

Birth Date___________________________Social Security #_____________________________________

Home Phone______________________________Cell Phone_____________________________________

Employer____Work Phone_________________________

Consent for Consultation and Payment

I, the undersigned, consent to receive endodontic consultation which may involve diagnostic x-rays, testing the condition of the teeth, and examination of surrounding tissues. If endodontic treatment is needed, the treatment may consist of more than one appointment requiring several x-rays and administration of a local anesthetic.

I also understand that only root canal treatment will be performed at this office and I am to return to my regular dentist for permanent restoration (filling, crown, etc.) of the treated tooth / teeth.

Notice regarding dental insurance: *Insurance policies are contracts between the patient and their insurance company and do not absolve the patient of financial responsibility for services rendered. Our office may file an insurance claim for dental services but any portion of the fees not covered by insurance remains the patient's responsibility.*

I acknowledge full responsibility for the payment for professional services rendered.

Method of payment: ☐ Cash ☐ Visa ☐ MasterCard ☐ Check ☐ Care Credit

____Date__________________________
Signature of Patient (Parent if Patient is a Minor)