OREGON ENDODONTIC GROUP
LEILA TARSA D.D.S., M.S.
Practice Limited to Endodontics
5665 MEADOWS RD. SUITE #105, LAKE OSWEGO, OR 97035
PHONE: 503.636.3383 FAX: 503.635.8632

PATIENT INFORMATION

Name_____
Last First Middle Initial

Address_____

City_____State_____Zip Code_____

Cell Phone:_____Work Phone:_____Home Phone:_____

Birthdate_____Social Sec #_____

Whom may we thank for referring you to our office?_____

Responsible Party Information (If Under age 18)

Name_____
Last First Middle Initial

Mailing Address_____
Street City State Zip

How long at this address?_____Home Phone_____Work Phone_____

Social Sec. #_____Birthdate_____Relationship to Patient_____

Employer_____Occupation_____

(Primary or Secondary Insurance Holders Information if different than patient)

Name_____Relationship to Patient_____
Last First M.I.

Employer_____Occupation_____

Social Sec. #_____Birthdate_____Work Phone_____

Insurance Information

Primary Insurance

Name of Company_____
ID #:_____Local #_____
Group #:_____

Secondary Insurance

Name of Company_____
ID #:_____Local #_____
Group #:_____

Emergency Contact Information

Name_____Relationship to patient_____
Last First M.I.

Address_____
Street City State Zip

Cell Phone_____Work Phone_____

Terms and conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service preformed without prior financial arrangements, must be paid for at the time services are preformed.

I understand that dental services furnished to me are directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help me prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

There is a $30.00 service fee on all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check or cash).

Assignment of Insurance: I hereby authorize release of any information needed and also authorized my insurance company to pay directly to This Office benefits accruing to me under this policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Patient or Guardian's Signature Date Guardian's relationship to Patient