

Advanced Endodontics of Houston
Anthony A. Zamany, D.D.S., M.S.D.
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Houston, TX 77063
713-266-5900. Fax: 713-266-1080

PATIENT INFORMATION

Last Name _____ First _____ Middle _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Business _____ Cell _____
Sex _____ Date of Birth _____ Social Security Number _____
Email address _____
Employer Name _____ Occupation _____
Address _____
City _____ State _____ Zip Code _____
Driver's License Number _____ State _____ Marital Status _____
Spouse's Name _____
Referred By _____
Present Dentist _____
Chief complaint _____

DENTAL INSURANCE INFORMATION

Insured's Name _____
Insured's Social Security Number _____ Insured's Date of Birth _____
Insurance Company _____ Insurance Phone _____
Employer _____ Group Number _____
Employer Phone _____
Secondary Insurance Company _____

FINANCIAL POLICY AND INSURANCE ASSIGNMENT

I, the undersigned certify that I (or my dependent) have insurance coverage with the above stated company and assign directly to Dr. Zamany all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event that the insurance company does not make a payment towards my account within 90 days, I will remit payment for the full balance as expected. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Date _____

Although this office files insurance claims as a service to our patients, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.