COVID-19 SCREENING QUESTIONS

Date_____

Name_____

Temperature_____

In the past 14 days, have you or any household member been tested for OR had COVID-19 OR had any contact with a known COVID-19 patient? ☐YES ☐NO

Have you had any COVID-19 symptoms such as fever, cough, sore throat or any respiratory illness in the past 14 days? ☐YES ☐NO

Have you attended any gathering in the past 14 days that had over 50 people in attendance? ☐YES ☐NO

In the past 14 days, have you or any household member traveled outside the state of INDIANA? ☐YES ☐NO

If yes, please note location:_____

Do you have uncontrolled dental pain, infection, swelling or bleeding or trauma to your mouth? ☐YES ☐NO

PAYMENT METHOD YOU WOULD LIKE TO USE TODAY

☐CHECK ☐VISA ☐MC ☐DISCOVER ☐CASH

CREDIT CARD NUMBER_____

EXPIRATION_____ **CVV CODE**_____

SIGNATURE_____ **DATE**_____

THE ENDODONTIC CENTER OF SOUTHERN INDIANA
DR. ALLEN MEIER D.D.S., M.S.D.

The Endodontic Center of Southern Indiana is a fee for service dental specialty practice. We will kindly request that all accounts be settled at the time services are rendered. We are a preferred provider for DELTA DENTAL PREMIER & HEALTH RESOURCES.

We do not accept insurance as initial payment for your consultation visit. If we accept your insurance, and are able to verify your dental benefits, we do ask you pay your ESTIMATED PORTION NOT COVERED BY INSURANCE TODAY. This ESTIMATE is based solely on information from your insurance carrier and is no way a guarantee of payment.

To avoid any misunderstanding regarding dental insurance, we wish to emphasize that as dental care providers, our relationship is with you, not your insurance company. We have no control over the method or amount of payment we receive from your insurance carrier. After the insurance payment is applied to your account, the remaining balance is your responsibility. This balance is due within 30 days after we receive your insurance payment.

IF YOU DO NOT HAVE DENTAL INSURANCE, WE DO ASK FOR PAYMENT IN FULL FOR THE SERVICES YOU RECEIVE TODAY.

The undersigned hereby guarantees all indebtedness incurred herein, and in the event this account is turned over to collections, shall be responsible for all costs incurred, including but not limited to reasonable attorney fees.

Please circle which of the following methods of payment you will be using today.

CASH CHECK VISA MC DISCOVER HSA

SIGNATURE: _____ DATE:_____

-FOR OFFICE USE ONLY-

PRIMARY INSURANCE	SECONDARY INSURANCE
SUBSCRIBER SS#/ID# _____	SUBSCRIBER SS#/ID# _____
SUBSCRIBER DOB _____	SUBSCRIBER DOB _____
PATIENT DOB _____	PATIENT DOB _____
DEDUCTIBLE$	DEDUCTIBLE$
YEARLY MAX$ AMT REM $	YEARLY MAX$ AMT REM $
USED TO DATE$	USED TO DATE$
ENDO %U/C	ENDO %U/C
LIMITATIONS-	LIMITATIONS-
ESTIMATE DUE$ _____	ESTIMATE DUE $_____

EVALUATION - $85.00
3D CB XRAY - $150.00 - NOT COVERED BY MOST INSURANCES

Click SUBMIT button to send your completed form to our office (only works in Adobe Acrobat).
If you're having problems, please give us a call at 812-333-6363

SUBMIT