

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 DOB _____
PATIENT DOB _____

SUBSCRIBER SS#/ID# _____
SUBSCRIBER DOB _____
PATIENT DOB _____

DEDUCTIBLE\$
YEARLY MAX\$ AMT REM \$
USED TO DATE\$
ENDO %U/C
LIMITATIONS-

DEDUCTIBLE\$
YEARLY MAX\$ AMT REM \$
USED TO DATE\$
ENDO %U/C
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 812-482-7668