GAYLE OBERMAYR, DDS, MS
PRACTICE LIMITED TO
ROOT CANAL THERAPY AND MICROSURGERY
WITH COMFORT AND EXCELLENCE
HEARTLAND ENDODONTICS

WELCOME TO OUR OFFICE

In order to make your dental care a more personal and complete health service, we ask that you please complete the following information

First Name _____ Nickname _____

Last Name _____ Please circle: Dr., Rev., Mr., Mrs., Ms., Miss

Address _____ Date of Birth _____

City/State/Zip _____ Home Phone _____

Social Security # _____ Cell Phone _____

Employer _____ Work Phone _____

Person responsible for account (if different from above)

_____ Daytime Phone _____

I acknowledge that I have received a copy of this office's NOTICE OF PRIVACY POLICY _____
Initials

PAYMENT INFORMATION

Payment is due in full at the time of treatment (unless prior arrangements have been approved). Our office will file your insurance claim when your treatment is completed so that your insurance company will reimburse you promptly.

I (patient / guardian) understand that I am responsible for payment of fees for services rendered.

_____ _____
Signature (Patient / Guardian) Date

Dental Insurance Information

Insurance Company_____ Insured's Social Security _____

Insured's Employer _____ Group # _____

Insured's Name _____ Insurance Phone _____

Relation to Patient _____ Insurance Address _____

Insured's Birth Date _____ _____

Pharmacy Name _____ Phone _____

Whom may we thank for referring you to our office _____

4660 Lakeview Drive ❋ Sebring, Florida 33870 ❋ (863) 382-9947