WHITE BEAR LAKE
ENDODONTICS

WENDY GULDEN D.D.S., M.S.
651-429-3535
4437 Lake Avenue South
White Bear Lake, MN 55110

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. (circle one) Maiden Name: ____________________
Name: (last) ____________________ (first) ____________________ (middle) ____________________
Complete Street Address: ____________________
City, State, Zip Code: ____________________
Home Phone: ____________________ Birthdate: ____________________ Social Security No. ____________________
Work Phone: ____________________ Relationship to Responsible Party: ____________________
Cell Phone: ____________________
Other children in the family (please list names and ages): ____________________

How did you choose our dental office? ( ) General Dentist ( ) Family/Friend ( ) Location ( ) Signage
( ) Web Site Other ____________________ Referring Dr. ____________________

Responsible Party Information

Dr. Mr. Mrs. Ms. (circle one) Maiden Name: ____________________
Name: (last) ____________________ (first) ____________________ (middle) ____________________
Complete Street Address: ____________________
City, State, Zip Code: ____________________
Home Phone: ____________________ Work Phone: ____________________
Social Security No. ____________________ Birthdate: ____________________
Employer: ____________________
Spouse's Name: (last) ____________________ (first) ____________________ (middle) ____________________
Spouse's Employer: ____________________ Spouse's Social Security No. ____________________
Occupation: ____________________

Insurance Information

Policyholder's Name: ____________________ Relationship to Patient: ____________________
Social Security No. ____________________ Birthdate: ____________________
Insurance Company: ____________________ Group No. ____________________
Insurance Co. Address: ____________________
Employer: ____________________
If the patient is a student, name of university, college or trade school: ____________________
DO YOU HAVE DUAL COVERAGE? No ☐ Yes ☐ If yes, please complete the following
Policyholder's Name: ____________________ Relationship to Patient ____________________
Social Security No. ____________________ Birthdate: ____________________
Insurance Company: ____________________ Group No. ____________________
Insurance Co. Address: ____________________
Employer: ____________________

Emergency Information

Name of nearest relative not living with you: ____________________ Phone: ____________________

I certify the above information is true and correct, and I agree to full financial responsibility of all charges for treatment rendered, regardless of insurance involvement.

IF YOU HAVE INSURANCE - Insurance is designed to reimburse the policyholder for loss, and is a contract between the policyholder and the insurance company. As a courtesy to you, we will submit your insurance claims on your behalf and will do all we can to help you collect legitimate claims. In the event your insurance is slow to pay or disallows the claim payment, the amount owed is your responsibility.

Signature (parent's signature if a minor): ____________________ Date: ____________________

I agree that where appropriate, credit bureau checks may be obtained.

Signature (parent's signature if a minor): ____________________ Date: ____________________