

CATHERINE E. WURM, D.D.S., M.S.

## **Kruchten Court Center**

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Email: info@centralmnendo.com Website: www.centralmnendo.com

Patient's Name	Appointment Date:
Birth Date	Time:Dr:
Phone # (h)(w)(c)	□ Evaluation or □ Treatment
	Insurance Company and Address:
□ Please call patient □ Radiographs (sent in mail) □ Radiographs emailed: info@centralmnendo.com  1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	Policy Holder Name:
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	
Please indicate a Restorative Directive.  Note: All teeth to be temporized will have an orifice barrier placed unless otherwise directed.  Temporary Only:  Permanent Restoration:  Amalgam  Sponge/Fuji  Fuji only  Leave post space	□ ✓ here if patient uses □ Endodontic treatment Nitrous □ Perforation □ Resorption
Remarks:	<ul> <li>1. Medication Note:</li> <li>Patients with artificial joints must be covered with antibiotics for the examination appointment. Use your orthopedic surgeon's guidelines.</li> </ul>
	2. Insurance Note: Patients will be required to pay deductible and co-insurance amount at the time of service. Please contact your insurance carrier prior to your appointment to determine coverage.
Dr. Signature:	Patients under 18 years of age must be accompanied by a parent or legal guardian.
Dr. Printed Name	Date: Office Phone:

