Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have any questions we'll be glad to help you.
We look forward to working with you in maintaining your dental needs.

PATIENT INFORMATION

Name___________________________ Social Security #_______________ Birthdate___________ Age_____

Address____ City_______________ State_____ Zip_______

Home phone#________________ Mobile phone#_________________ E-mail address______________________

Sex___M___F ___Single ___Married ___Separated ___Divorced ___Widowed

Employer___________________________________ Occupation________________________________

Business Address_______________________________________ Business Phone #_________________

Spouse's Name_________________________ Social Security #__________________ Birthdate______________

Spouse's Employer_______________________________ Spouse's Business Address________________________________

Spouse's Business Phone #____________________

In case of emergency who should be notified?__________________________________ Phone #_________________

Whom may we thank for referring you?_____________________________________

INSURANCE INFORMATION

Name of Dental Insurance________________________________ Group #_________________________

Address of Insurance Company____________________________________ Phone #___________________________

Name of Insured___________________________ Relationship to patient_________________________

Name of Secondary Insurance_____________________________ Group #_________________________

Address of Insurance Company____________________________________ Phone #___________________________

Who is responsible for the account? ____

Relationship to patient____

I certify that the above information is accurate and complete to the best of my knowledge. I give Dr. Giacalone and her staff permission to submit any records including radiographs and photos to any third party requiring this information for processing my dental work or insurance claims. I understand that filing insurance claims is a service provided without charge and in no way relieves me of responsibility for my bill. It is the policy of this office to extend a limit of 45 days for the assignment of insurance benefits. Forty five days after services have been rendered payment is due in full. Be advised the policy of this office is interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to all accounts over 45 days, regardless of the insurance involvement. There will be a $10.00 handling fee for any RETURNED CHECKS.

Patient Signature/Responsible Party:___________________________________ Date: __________________________