



Welcome

We are pleased to welcome you to our dental practice. Please take a few minutes to fill out this form completely.
You can trust you smile with us!

PATIENT INFORMATION(CONFIDENTIAL) DATE _____

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Sex ___M___F Birthdate _____ SS# _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient Employer _____ Occupation _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified? _____ Phone _____

FINANCIALLY RESPONSIBLE PARTY Please complete if patient is under 18 years.

Relationship to Patient _____

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Sex ___M___F Birthdate _____ SS# _____ Marital Status _____

Home Phone _____ Work Phone _____ Cell Phone _____

I understand that I am responsible for payment of bill regardless of whether my insurance carrier pays or does not pay for my dental treatment/services.

X _____ Date _____

Signature of Patient or Parent if Minor

**PLEASE PRESENT YOUR DENTAL INSURANCE CARD/FORM TO THE FRONT DESK
PRIMARY DENTAL INSURANCE**

Insurance Name _____ Group # _____ ID# _____

Phone Number _____ Name of Employer _____

Employee Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Sex ___M___F Occupation _____ Birthdate _____ SS# _____

Is Patient Full Time Student ___ Part Time Student ___ Relationship to Patient _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Angelo Carnevale all insurance benefits. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may provide such information to the above named insurance company and their representatives for the purpose of obtaining payment for services and/or determining insurance benefits.

X _____ Date _____

Signature of Insured

X _____

Please Print

Relationship to Patient