PARATO FAMILY DENTAL

Patient Information Form

PATIENT

Name ____

Address ____

____

How long at this address? _____________________________

Phone Number ____________________________________

Mobile Number ____________________________________

Email ____

Social Security # ___________________________________

Driver's License # __________________________________

Age _______________ Date of Birth ___________________

RESPONSIBLE PARTY (Skip if same as above)

Name ____

Address ____

____

How long at this address? _____________________________

Relationship to patient _______________________________

SS# __________________ Driver's Lic. #________________

Age __________________ Date of Birth ________________

EMPLOYMENT

Occupation _______________________________________

Employer ____

Length of employment ________________________________

Business address ___________________________________

____

Business phone _____________________ Ext. ___________

EMERGENCY CONTACT

Name ____

Contact Number ____________________________________

Relationship to patient _______________________________

*(Please complete both sides)

HOW DID YOU HEAR ABOUT US?

- ☐ Family/friends
- ☐ Office sign
- ☐ Flyer/coupon
- ☐ Insurance Plan
- ☐ Newspaper
- ☐ Our website
- ☐ Facebook
- ☐ Radio
- ☐ Yellow pages
- ☐ Online ad
- ☐ Other/s ____________________________

Do you have family or friends who may need dental care?

If so, please list name(s) and (relationship (s):

Were you referred by anyone? ☐ Yes ☐ No

Name ____

INSURANCE / DENTAL PLAN (primary)

Plan Name ____

Address ____

____

Insurance/Plan Phone # _______________________________

Insured's name _____________________________________

Union _________ Group # ___________ Plan # _____________

Insured's SSN# _________________ Date of Birth ____________

INSURANCE / DENTAL PLAN (secondary)

Plan Name ____

Address ____

____

Insurance/Plan Phone # _______________________________

Insured's name _____________________________________

Union _________ Group # ___________ Plan # _____________

Insured's SSN# _________________ Date of Birth ____________

1.I certify that the information provided is accurate and will be used to grant credit and provide dental services. I understand that I am financially responsible for all charges not covered by or paid by my insurance for any reason.
2.By signing below, I authorized that you may verify and exchange information on me and any additional applicants, including reports from credit reporting agencies.
3.I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by this authorization. I authorize release of any information relating to any dental claim(s).
4.I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Patient or Responsible Party (Parent if patient is minor) ____________ Date