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PATIENT INFORMATION

Patient's Name _____ Birthdate _____

Who referred you to this office _____ Social Security # _____Today's Date _____

Address _____ City _____ ST_____ ZIP _____

Home Phone _____ Work Phone_____ Ext _____

Cell Phone _____ E-Mail _____

Employer_____ City _____ Occupation _____

Name of Parent /Partner/ Spouse / Guardian _____ Birthdate _____
(circle one) Social Security # _____

Address if different _____ City_____ST _____ZIP_____

Home Phone_____ Work Phone _____ Ext_____

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify?

Name _____Relationship_____ Phone _____

PRIMARY DENTAL INSURANCE

EMPLOYEE NAME_____

INS CO NAME _____

INSURANCE PHONE_____

GROUP / POLICY # _____

SUBSCRIBER ID #_____

SUBSCRIBER BIRTHDATE _____

SECONDARY DENTAL INSURANCE

EMPLOYEE NAME _____

INS CO NAME _____

INSURANCE PHONE _____

GROUP / POLICY #_____

SUBSCRIBER ID # _____

SUBSCRIBER BIRTHDATE _____

Patient Acknowledgments:

- I understand that all charges incurred are **payable in full at the time of service**.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I consent to the publication of my photos released to Dr. Maragliano-Muniz by any other healthcare providers.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor