Welcome to Janine Randazzo Dentistry

How did you hear about us? ____

Patient Information

Last Name __________________________ First Name ___________________ MI ____
Prefers to be called ___________________ Date of Birth ______________ Gender _____
Street Address ____ Apt. _______
City, State, Zip __________________________________ SS # ___________________
Home Phone ______________ Work Phone ______________Cell Phone ______________
Email Address ____
Marital Status ___________ Preferred method of confirmation ____________
Employer Name______________________________________ Occupation ___________
Please list other family members treated at this practice ____________________________
Emergency Contact Name ______________________________ Phone _______________

Parent/Guardian Information if Patient Under 18 years old

Last Name _____________________________ First Name ________________ MI ____
Gender ____ Date of Birth ____________ Does this person and patient reside in the same household? ______
Street Address (if different) ______________________________________ Apt. _______
City, State, Zip ___________________________________ SS # ___________________
Home Phone ______________ Work Phone ______________Cell Phone ______________
Employer Name__________________________________ Occupation ______________

Insurance Section

Is Patient covered by Dental Insurance? ______ Name of Carrier(s) ______________________
Subscriber's Name _______________________Subscriber Number ___________________
Employer's Name ____
Date of Birth ________ Gender____ Relationship to Patient: Self Spouse Parent/Guardian

All accounts that are 45 days or older will be charged a $75.00 late fee. The returned check fee is $75. Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment, and all applicable court costs. *I understand that I am financially responsible for all charges incurred; including those my insurance company does not pay in full or in part.*

Signature____ Date _____________