Welcome to Randazzo Dentistry

Who can we thank for referring you to 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 _____
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 _____

Insurance Section

Is Patient covered by Dental Insurance? _____ Name of Carrier(s) _____
Subscriber's Name ____ _____ Employer's Name _____
Date of Birth _____ Gender____ Relationship to patient _____

I understand that I am financially responsible for all charges incurred; including those my insurance company does not pay in full or in part. All accounts that are 45 days or older will be charged a $75.00 late fee. The returned check fee and appointment cancelation 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 treatment, and all applicable court costs.

_____ _____
Date Signature of Patient/Parent/Guardian