

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