

# Welcome to Dr. Curotto's Dental Practice

Thank you for selecting our dental healthcare team. We will provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## 1— Personal Information

Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Call me by this name \_\_\_\_\_  
 Male  Female  Minor  Single  Married  Divorced  Widowed  Separated

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

## 2— Responsible Party (Who is responsible for the account?)

Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Birth Date \_\_\_\_\_ Driver's License # \_\_\_\_\_

Social Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Extension # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## 3— Telephone Contact Information

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Extension # \_\_\_\_\_

Cell Phone \_\_\_\_\_ Prefer to receive calls at  Home  Work  Cell

Best times & days to reach me: Times \_\_\_\_\_ Days \_\_\_\_\_

My EMERGENCY contact is... Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency contact Work # \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_

# 4— Dental Insurance Information

## Primary Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_  
Social Sec. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Additional Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_  
Social Sec. # \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Employee/Cert. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Deductible \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

# 5— Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient or parent/guardian if minor

Date

# 6— Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

Payment in full at each appointment.

\_\_\_\_\_ Cash

\_\_\_\_\_ Personal Check

\_\_\_\_\_ Credit Card \_\_\_\_\_ Visa \_\_\_\_\_ MC

\_\_\_\_\_ I wish to discuss the dental office's policy.

## Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.