Dr. Louise C. De Felice, DDS
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PATIENT INFORMATION

Date:_____

Patient's Name:_____
Last First Middle

Mailing Address:_____
street city/state zip code

Date of Birth:_____ Social Security #_____

Home Phone:_____ Cell Phone:_____

If a patient is a minor, parent/guardian's name:_____

Whom may we thank for referring you to our office?_____

GUARANTOR INFORMATION

Name:_____
Last First Middle

Relationship to patient_____

Residence:_____
street city/state zip code

Mailing Address:_____
street city/state zip code

How long have you been at this address? _____

Previous address if less than 3 yrs._____
street city/state zip code

Date of Birth:_____ Social Security #_____

Email address:_____

Employer/Occupation:_____ Employer Phone #_____

Spouse's Name:_____
Last First Middle

Relationship to patient:_____

DENTAL INSURANCE INFORMATION

Subscriber's Name:_____ Subscriber's Social Security #_____

Insurance Company:_____ Group #:_____ Local #:_____

Insurance co. address:_____
Street City/state Zip Code

Do you have dual coverage (circle one)? YES NO If yes:

Insurance Company:_____ Group #:_____ Local #:_____

Insurance co. address:_____
Street City/state Zip Code

EMERGENCY INFORMATION

Name of nearest relative not living with you:_____

Address:_____
street city/state zip code

Phone:_____

ASSIGNMENT OF BENEFITS:

I hereby assign any/all dental/medical benefits to which I am entitled through my health insurance be paid directly to De Felice Dentistry. I understand that I am responsible for all costs of dental treatment.

_____

SIGNATURE (guarantor if patient is a minor or not responsible for payment) DATE

_____

PRINTED NAME