Pallotto Dental Care

Personalized & Comfortable

1. PATIENT INFORMATION Married/Single/Minor/Widowed/Divorced

Name_____ Male /Female

Address_____

Street City State Zip Code

Birth Date _____SS #_____

Home Phone #_____ Cell # _____

Employer_____ Work# _____

Employer Address

_____

Street City State Zip Code

Email(s)_____

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

2. RESPONSIBLE PARTY INFORMATION (*If someone other than the patient)*

Name_____ Male /Female

Address_____

Street City State Zip Code

Birth Date _____SS #_____

Home Phone #_____ Cell # _____

Employer_____ Work# _____

Employer Address

_____

Street City State Zip Code

Email(s)_____ ☐ I'd like to receive correspondence by email.

PRIMARY DENTAL INSURANCE INFORMATION	**SECONDARY DENTAL INSURANCE INFORMATION**
Insurance Company Name :	**Insurance Company Name :**
_____	_____
Insurance Company Address :	**Insurance Company Address :**
_____	_____
Insurance Company Phone # :	**Insurance Company Phone # :**
_____	_____
Group# _____	**Group#** _____
Insurance ID #_____	**Insurance ID #**_____
Policy Owner's Name:	**Policy Owner's Name:**
_____	_____
Relationship to Patient_____	**Relationship to Patient**_____
Policy Owner's Birth date_____	**Policy Owner's Birth date**_____
Policy Owner SS# _____	**Policy Owner SS#** _____
Policy Owner's Employer_____	**Policy Owner's Employer**_____

SIGNATURE OF RESPONSIBLE PARTY _____Date_____

Please Print _____

(Relationship to Patient) _____

FOR OFFICE USE ONLY

For those patients whose responsible party is not present at time of appointment, form to be re-filled out by responsible party and to be:

☐ **faxed,** ☐ **emailed,** ☐ **or mailed.** **Initial** ☐