JOSEPH P. SANFELIPPO DDS, SC
FAMILY DENTISRY

PATIENT______________________________________ BIRTHDATE ___/___/___

RESPONSIBLE PARTY INFORMATION

NAME (if different than above)____

ADDRESS____ ZIP____________

PHONE#__________________ EMERGENCY PHONE#____________________________

EMPLOYER______________________ EMPLOYER PHONE#_________________________

BIRTHDATE_________________________ E-MAIL________________________________

SOCIAL SECURITY#________________ DRIVERS LICENSE#________________________

INSURANCE INFORMATION

SUBSCRIBER /MEMBER NAME ____

EMPLOYER/ UNION ____________________________PHONE#______________________

INSURANCE COMPANY____

SOCIAL SECURITY# _____________________________ BIRTHDATE_______________

I hereby authorize the office to bill my Insurance Company for payment of dental benefits, otherwise payable to me, sent directly to Dr. Sanfelippo. I agree to authorize release of personal information as needed for Insurance and billing purposes.

SIGNATURE____DATE__________________

Do you have any present dental problems?____

What would you change about your smile?____

How did you find out about our office?____

Who may we thank for your referral?____
We like to welcome our new patients and put their names on our welcome board, if you would prefer not to please initial here.________