Welcome to Dr. Mastrota's office

Thank you for choosing our office! We will strive to provide you with the best possible dental care. To help us meet your dental needs, please fill out this form completely. If you have ant questions or need assistance, please ask. We will be happy to help.

Patient Information (Confidential) Date _____/_____/_____ SSN_____ _____

Name: □**Mr.**□**Mrs** □**Dr.**□**Ms** □**other**_____

Address_____City_____State_____Zip_____

Home Phone(____)_____ Cell Phone(____)_____ Work Phone(____)_____

Birthdate____/____/_____ If Student, Name of School_____

Patient or Parent/Guardian's Employer_____

Business
Address_____

Spouse or Parent/Guardian's Name_____Employer_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone(____)_____

Responsible Party

Name of person responsible for this account_____Relationship_____

Address_____Phone(____)_____

Employer_____Work Phone(____)_____ SSN_____
Is this person currently a patient at our office? ☐ Yes ☐ No
Would you be interested in discussing our office payment plan? ☐ Yes ☐ No

Insurance Information Please give your insurance card to the front desk.

Name of Insured _____Relationship_____

Birthdate____/____/_____ SSN_____

Name of Employer_____

Insurance Company_____Group#_____

DO YOU HAVE ADDITIONAL INSURANCE? □ YES □ NO
Name of insured_____Relationship_____

Birthdate___/___/____ SSN_____

Name of Employer_____Insurance Company_____