

# Welcome to Dr. Mastrotta'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 any 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 \_\_\_\_\_