- Patient Information

First Name _____ Last Name _____

Address _____

City _____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell_____

DOB _____ SS#_____

E-Mail _____

Responsible Party (if other than patient)

First Name _____ Last Name _____

Address_____

City _____ State_____ Zip_____

Home Phone _____ Work Phone_____ Cell_____

DOB _____ SS#_____

E-Mail_____

Primary Insurance Information

Name of Insured_____ Relationship_____

Insured SS# _____ Insured DOB_____

Employer _____ Ins company_____

Group # _____ Patient Id#_____

- I hereby authorize Frank J. Sapere DDS to administer any treatment and to perform such x-rays anesthetics and dental procedures as may be deemed necessary or advisable in the diagnosis and treatment of my dental condition.
- I Authorize the release of any information relating to this claim. I realize that I am ultimately responsible for all costs of dental treatment
- I hereby authorize insurance benefits to be paid directly to Frank J. Sapere

Signature_____ Date _____

After initial X-rays and examination, we will give you an estimate of the fees to cover your treatment. At that time financial arrangements will be made before any treatment is rendered.