Patient information

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone_____ Cell _____

DOB _____ SS# _____

Email _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

How did you hear about us?

- ☐ Google
- ☐ Facebook
- ☐ Instagram
- ☐ Friend/Family Referral _____ (please include referral name so we can thank them!)
- ☐ Walk by/Drive by
- ☐ Other _____

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Responsible Party (if other than patient)

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone_____ Cell _____

DOB _____ SS# _____

Email _____

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Primary Insurance Info

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 hereby 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 DDS

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.