DENTAL OFFICE OF DR. MICHAEL MANELA

PATIENT INFORMATION

Patient Information: Please Print Legibly Date: _____

Name: _____ Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Add'l Phone: _____

Marital Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Who may we thank for referring you? _____

Responsible Party: Please Print Legibly

Individual Responsible for Account: _____

SSN#: _____ Birth Date: _____

Is this person currently a patient in our office? Yes ☐ No ☐

Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Add'l Phone: _____

Dental Insurance: Yes ☐ No ☐ If yes, Name of Ins. Co.: _____

Address: _____ Group #: _____

Phone: _____ Deductible Amt.: _____ Ins. Maximum: _____

Have you used any of your insurance this calendar year? Yes ☐ No ☐

Secondary Ins. Information: Please complete if you are covered by two insurances

Name of Insured: _____ Birth Date: _____

SSN#: _____ Name of Employer: _____

Home Phone: _____ Work Phone: _____ Add'l Phone: _____

Ins. Co. Name: _____ Address: _____

Group #: _____ Phone: _____ Deductible Amt.: _____

Ins. Maximum: _____ Have you used any of your insurance this calendar year? Yes ☐ No ☐

I hereby authorize treatment for my dental health care. I understand that I am financially responsible to this office for professional fees & services. I also understand that the contract between my insurance company and myself is based on "usual and customary" charges and that I am responsible for all deductibles and co-payments at the time of my visit. I also understand that there will be times that my insurance does not cover all amounts and I am responsible for said amounts. If it is ever necessary for this office to employ collection counsel, I understand that I am responsible for these charges.

Signature: _____

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