JOSEPH P. SANFELIPPO DDS, SC

PATIENT_____ BIRTHDATE ___/___/___

RESPONSIBLE PARTY INFORMATION

NAME (if different than above)_____

ADDRESS_____ ZIP_____

PHONE#_____ EMERGENCY PHONE#_____

WORK or CEL PHONE#_____EMPLOYER_____

BIRTHDATE_____ E-MAIL_____

I ALLOW USE OF MY EMAIL FOR DENTAL CORRESPONDENCES _____ _____
Initial Date

SOCIAL SECURITY#_____ DRIVERS LICENSE#_____

DENTAL INSURANCE INFORMATION

SUBSCRIBER /MEMBER NAME _____

EMPLOYER/ UNION _____PHONE#_____

INSURANCE COMPANY_____

SOCIAL SECURITY# _____ BIRTHDATE_____

Do you have any present dental problems?_____

What would you change about your smile?_____

How did you find out about our office?_____

Who may we thank for your referral?_____

We like to welcome our new patients and put their names on our welcome board, if you agree to have your name placed on the board please initial here._____

I authorize release of my dental information to_____ _____ _____
Initial Date

I hereby state that the information is accurate and correct to the best of my knowledge. I hereby authorize and consent to have Dr. Sanfelippo diagnose and administer treatment. I hereby authorize the office to bill my Insurance Company for payment of dental benefits, otherwise payable to me, sent directly to Dr. Sanfelippo. I agree to authorize release of personal information as needed for Insurance and billing purposes.

SIGNATURE_____DATE_____