Dr. Villago and staff welcome you to our office!

PATIENT INFORMATION

DATE_____ SS#:_____

PATIENT NAME:_____
LAST NAME FIRST NAME MI

ADDRESS:_____

SEX: M____ F____ AGE:_____ BIRTHDATE:_____

MARRIED:____ SINGLE:_____ WIDOWED____ SEPARATED_____ DIVORCED____ MINOR_____

PHONE NUMBER

CELL:_____CELL PHONE PROVIDER:_____

HOME:_____ SPOUSE CELL:_____

PATIENT EMPLOYER:_____ PATIENT SCHOOL:_____

OCCUPATION:_____OFFICE PHONE NO,:_____

SPOUSE'S NAME:_____
LAST NAME FIRST NAME MI

SPOUSE BIRTHDATE:_____SPOUSE SS#:_____

SPOUSE EMPLOYER:_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE ? :_____

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? : YES_____ NO_____

INSURED NAME:_____

RELATIONSHIP TO PATIENT:_____ INSURED BIRTHDATE:_____

INSURANCE COMPANY:_____ GROUP #:_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE?: YES_____ NO_____

SUBSCRIBER'S NAME:_____

BIRTHDATE:_____ SS#:_____

2ND INSURANCE COMPANY:_____ GROUP #:_____

ASSIGNMENT OF RELEASE

I CERTIFY THAT I, AND/OR MY DEPENDENT (S), HAVE INSURANCE COVERAGE WITH _____
INSURANCE COMPANY

AND ASSIGN DIRECTLY TO **Dr. GLORIANA VILLAGO AND ASSOCIATES** ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.**Dr. GLORIANA VILLAGO THE ASSOCIATES** MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OF THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR UNTIL I DECIDE TO LEAVE THE PRACTICE AND SWITCH DENTISTS.

_____ _____
SIGNATURE OF PATIENT/PARENT PRINT NAME OF PATIENT/PARENT

_____ _____
DATE RELATIONSHIP TO PATIENT

EMERGENCY CONTACT: NAME_____PHONE #:_____

RELATIONSHIP TO PATIENT:_____