



## PATIENT AND RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Last First M

Date of Birth \_\_\_\_\_ \_\_Male \_\_Female \_\_Married \_\_Single \_\_Minor/Other

Home Address \_\_\_\_\_  
Street and Apt # City, State Zip Code

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell/Other# \_\_\_\_\_  
(please circle the number that you would prefer for us to use to contact you)

E-mail address \_\_\_\_\_ If you provide an email address, we will enroll you in Dental Sesame - our free service for email appointment reminders, online account information, and online payments. (Your email address will be kept private)

How were you referred to our office? \_\_\_\_\_

Who will be responsible for charges incurred on this account? (name on the billing account)

Name Relationship to patient Phone #, if different SSN of responsible party

Billing Address (if different) \_\_\_\_\_  
Street and Apt # City, State Zip Code

***If other immediate family members (spouse, children, etc.) are patients of record in our office, we will automatically add you to the same billing account unless you request otherwise.***

## PRIMARY INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD IF YOU HAVE ONE)

Policyholder/Subscriber's Name \_\_\_\_\_  
Last First M

Patient's relationship to Subscriber \_\_Self \_\_Spouse/Partner \_\_Child/Stepchild

Subscriber's ID/SSN # \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Insurance company \_\_\_\_\_

Customer Service Phone # \_\_\_\_\_ Group #: \_\_\_\_\_

***If you have secondary insurance coverage, please let us know so that we may add it to our records as well.***

I certify that the above information is true, to the best of my knowledge. If any of this information changes, I will provide that information to Dr. Del Rosario's office as soon as possible. I understand that failure to provide accurate insurance information in a timely manner may result in being billed for the full fee for any services provided to me.

Signature \_\_\_\_\_

Date \_\_\_\_\_