# Welcome to our Practice!

## PATIENT INFORMATION:

| Date of Birth | Last Name | First Name |
|---|---|---|
| | | |

| Preferred to be called | Email Address |
|---|---|
| | |

| Street Address | City, State, Zip |
|---|---|
| | |

| Cell Phone | Work Phone | Home Phone |
|---|---|---|
| | | |

| SS# | Driver's License | Sex (M/F) |
|---|---|---|
| | | |

| Employer | Address, City, State, Zip |
|---|---|
| | |

| Occupation | Emergency Contact Name | Phone # |
|---|---|---|
| | | |

| Spouse's Name | Occupation |
|---|---|
| | |

| Spouse's Address (if different than above) | City, State, Zip |
|---|---|
| | |

In the event that we must contact you for scheduling changes, etc, please indicate the best PHONE NUMBER during business hours to phone you:

| Phone # | Place | Time |
|---|---|---|
| | | |

How did you hear about our office?

Please check: ________ Internet ________ Patient referral ________Website ________Post Card Mailer __________ Radio ________Newsletter

________Open House ________Other (Please tell us)________________________________

If you were referred, whom may we thank for their trust in us?________________________________

## INSURANCE INFORMATION:

| Primary Insurance Company | Address |
|---|---|
| | |

| City, State, Zip | Phone # |
|---|---|
| | |

| Policy Holder Name | Member's ID# | Date of Birth |
|---|---|---|
| | | |

| Group # or Policy # |
|---|
| |

| Secondary Insurance Company | Policy Holder Name | Date of Birth |
|---|---|---|
| | | |

| Group # or Policy # |
|---|
| |

**I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement, directly to Michael A Petrillo DMD PC ("the Practice") of insurance benefits under which I am entitled. To the extent permitted by law, I consent to the Practice's (or its assignees/designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.**

**Date:**____________________________**Patient's Signature:** ________________________________

## CONSENT:

**I hereby authorize Lehigh Valley Smile Designs to take the necessary X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Lehigh Valley Smile Designs to make a thorough diagnosis of the patient's dental needs. I also authorize Lehigh Valley Smile Designs to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier and not between Michael A. Petrillo, DMD PC and your insurance company I fully understand that it is my responsibility entirely for all dental treatment regardless of insurance coverage.**

**Date:**____________________________**Patient's Signature:** ________________________________