NEW PATIENT INFORMATION

PRIMARY DENTAL INSURANCE

PATIENT NAME:_____________________________________DOB:___________________________

INSURANCE COMPANY NAME:____

SUBSCRIBER NAME:_____________________________DOB:_____________SSN:______________

EMPLOYER NAME:____

SECONDARY DENTAL INSURANCE

INSURANCE COMPANY NAME:____

SUBSCRIBER NAME: ___________________________DOB:_______________SSN:______________

EMPLOYER NAME:____

HOW DID YOU HEAR ABOUT US? ____

I authorize Fede Family Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Fede Family Dentistry otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

____ ________________________

Signature Date