

# Perio Aesthetics & Implantology, LLC.

Angela L. Blizzard, DMD & Alexandra Terrazzani, DDS

## PATIENT INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Married: Y N Other  
E-mail Address \_\_\_\_\_  
Employer \_\_\_\_\_

### PERSON RESPONSIBLE FOR ACCOUNT (if different from above)

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: M F Married: Y N Other  
E-mail Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Relationship to patient: Spouse  Parent  Other  \_\_\_\_\_

### PRIMARY INSURANCE INFORMATION

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ phone \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
ID# or SS# \_\_\_\_\_  
Is patient covered by another dental insurance? Y N If yes, please complete the information below.

### SECONDARY INSURANCE INFORMATION

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ phone \_\_\_\_\_  
Address \_\_\_\_\_  
Employer \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
ID# or SS# \_\_\_\_\_

### PATIENT SIGNATURE

DATE

*I hereby authorize the above-named insurance company or companies to release payment directly to Angela L. Blizzard DMD.*

*I understand that I am financially responsible for any fees not covered by my insurance.*