WELCOME TO OUR OFFICE

Patient's Name _____ Birthdate _____
Last First Middle

Address _____ Soc. Sec. No _____
Street

_____
City State Zip

Phone _____ CDL # _____
Home Bus/Msg

List Persons/Dependents covered on this account

First Name	Last Name	Sex	Relation	Birthdate

Employer _____ Phone _____

Address _____

_____ Phone _____

_____ Phone _____

Referred By: _____ Phone _____

Previous Dentist _____ Date last seen _____

PAYMENT IS REQUIRED AT TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE

INSURANCE INFORMATION

Insurance Company _____ Address _____

Subscriber's name _____ Policy Number _____

Regardless of Insurance coverage, deductible and/or Co-payment, I understand that I am fully responsible for any services rendered. Any accounts over 30 days will be charged a service charge of 1-1/2% per month (18% APR) or a minimum of $2.00 on any balance under $100.00.

I, the undersigned (patient or legally responsible party), authorize treatment to be rendered by Mark J. Romanelli, D.D.S., A Dental Corporation and his staff, and assume financial responsibility.

SIGNATURE _____ DATE _____

REV 1/06