

Insurance Information

Date _____
Patient's Name _____ Date of Birth _____ Sex _____
last first
Address _____ Telephone _____
ZIP _____
School _____ Grade _____

Father's Name _____
Father's Birthdate: _____
Father's Social Security # _____
Employed by: _____
Business Address: _____
Business Telephone: _____
Dental Insurance Company: _____
Dental Insurance Co Address: _____
Insurance Group # _____ Phone # _____

Mother's Name _____
Mother's Birthdate: _____
Mother's Social Security # _____
Employed by: _____
Business Address: _____
Business Telephone: _____
Dental Insurance Company: _____
Dental Insurance Co Address _____
Insurance Group # _____ Phone # _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Joseph A. Persichetti all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Persichetti may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date _____
Print Name _____ Relationship to Patient _____

