DeCarolis Dental Associates
24255 W. Thirteen Mile Rd., Suite 150, Bingham Farms, MI 48025
(248) 645-3700

NEW PATIENT GENERAL INFORMATION

Patient Name _____ _____ _____
Last First Middle

If child, parent's name_____

Patient Birthdate_____ Age_____ SS#_____

Married Single Separated Widowed Divorced

Address_____

_____

Home Phone_____ Business Phone_____

Cell Phone_____ E-Mail address_____
(For contact and promotional information)

Driver's license #_____

Referred by: _____

Who will pay this account _____

Patient Employer _____ Insurance Co._____

Dental Ins. Policy # _____ Dental Ins Phone #_____

SPOUSE INFORMATION Spouse Name _____ Birthdate _____

SS#_____ Spouse Employer _____

Spouse Ins Co._____ Policy # _____ Ins. Phone #_____

SIGNATURE ON FILE I authorize the use of this signature on **all** of my (and my dependents) insurance submissions. I authorize release of information to all my insurance companies. I understand that **I am responsible** for my bill. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to my doctor. I permit a copy of this authorization to be used in place of the original.

_____ _____
SIGNATURE DATE