

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

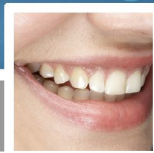
Birth Date: Prev. Visit: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:
 City State Zip Code

social security #

Whom may we thank for referring you to our practice?



Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone: Best time to call:
Home Work Ext Mobile

Address:

City State Zip Code

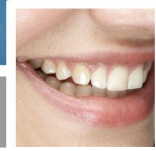
Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code



Primary Insurance Information

Primary Dental Insurance:

Name of Insured: Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code



Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:

Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Signature: _____

Date:

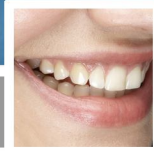
Benedict J. Parenti, D.D.S. P.C.

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Relationship to Patient:

Response Date: