

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

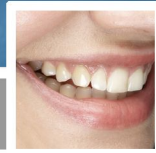
162 Painters Crossing #6

West Chester PA 19382

(610)558-4949

call4drben@verizon.net

parentdentistry.com



Patient Information

Chart #.

FOR OFFICE USE ONLY

Patient Name:
Last First MI Preferred Name

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

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

Address:

City State Zip Code

Referral Information

Name of person, office or other source referring you to our practice:

Spouse or Responsible Party Information

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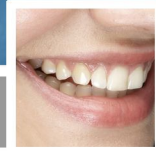
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The following is for: the patient's spouse the person responsible for payment neither-not applicable

Name:
Last First MI Preferred Name

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

Birth Date: SS #: Driver's License #:

Email Address: Best time to call:

Phone:
Home Work Ext Mobile Fax Other

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

Insurance Information

Primary Dental

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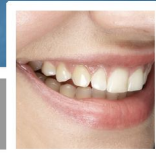
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Name of Insured:
Last First MI

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 Dental

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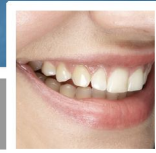
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Name of Insured:
Last First MI

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

Primary Medical

Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

Secondary Medical

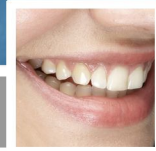
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Name of Insured:
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name:

If you could safely whiten your teeth would you?

Yes No

Response Date: