Dr. Patrick Delflore
Patient Information

Patient's First Name:_______________MI:___Last Name:_________________
Address:_____________________________City:_______________State:____Zip:_____
Home Phone:_______________Work Phone:_______________Cell Phone:____________
Sex:____Birth Date:___/___/___Social Security:_______________E-mail:____________
Patient's Marital Status:__Married__Divorced__Separated__Single__Widowed

Patient's Employer:______________________________
Address:_________________________City:___________State:___Zip:_________

Patient's School:____________________(Please Circle One)
Full Time Part Time Not a Student

Driver's License#:______________________
Emergency Contact:_________________Relationship:___________ Phone:__________
How did you hear of us?_____________________________________

Responsible Party

Person Responsible For payment of account if other then patient

Full Name:________________Relation to Patient:_____________Social Security#:____
Address:___________________________City:_________State:____Zip:________
Home Phone:______________Work Phone:_________________

Insurance

In order to process your insurance claim, we must have a copy of your current insurance card. All of the following information must be provided to file the claim

Name of Insured/Policy Holder:___________________________________
Address:______________________City:___________State:___Zip:_______
HomePhone:_________________WorkPhone:______________
Insured's Relationship to Patient: Self Spouse Parent Step-Parent Other:_____
Policy Holder Birth Date: ___/___/___ Policy Holder's SS#__________________
Name of Insurance Company:__________________Phone#:____________________
Claim's Address:______________________City:__________State:____Zip__________
Dental Insurance Policy#________________ Group # ________________
Policy Holder's Employer: ______________________ Employer Phone: _____________
Address:______________________________ City: ___________ State: ___ Zip: _______

By signing below, responsible party acknowledges the above information is correct and agrees to notify Dr. DelFlore as changes may occur. Responsible party also agrees to pay any deductible, co-pay, co-insurance, or other amounts not covered by insurance. The signature below serves as a "signature on file" authorizing Dr. Patrick DelFlore to release any dental records as required by law for appropriate care with other providers, to process any insurance claims, and to receive payment/insurance benefits otherwise payable to insured. Should responsible party not pay his/her portion as stipulated above, the responsible party shall be liable for payment of any late charges or collection fees that may result. **MISSED OR BROKEN APPOINTMENTS waste valuable manpower and raise fees for everyone. In an effort to reduce this expensive waste, we CHARGE for all broken appointments. <u>A charge of $50.00 will be assessed to you and will need to be paid before your next scheduled appointment.</u> A 48 hour notice is needed to be given to the office to avoid this fee. We adhere to this policy, so please take time to carefully select your appointment time. A 48 hours notice must be within our normal business hours of Monday through Friday, 9a.m.-5p.m.**

Signature:______________________________ Date:______________