PATIENT REGISTRATION


PETER D'ALOIA, D.D.S.
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## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Patient's last name: | First: | Middle: | |
| Address: | City: | State: | |
| Date of birth: | Social Security no.: | Sex ☐ M ☐ F | |
| Home phone: | Cell phone: | E-mail: | |

In the event that our office needs to contact you, we will use all methods. However, which is your first choice: Home phone: ☐ Cell phone: ☐

Whom may we thank for referring you to our office:

## PRIMARY INSURANCE - Responsible Party/Insurance Information

| | | |
|---|---|---|
| Do you have dental insurance: ☐ Yes ☐ No<br>If yes, please have your insurance card available. | Person responsible for this account or insurance subscriber: | |
| Relationship to patient: | Subscriber's birthday: | Social Security no.: |
| Insurance carrier: | Id: | Group No.: |
| Home phone: | Cell phone: | E-mail: |
| Employer: | Employer Address and telephone no.: | |

## SECONDARY INSURANCE (If any)

| | | |
|---|---|---|
| Name of insured: | | |
| Relationship to patient: | Subscriber's birthday: | Social Security no.: |
| Insurance carrier: | Id: | Group No.: |
| Home phone: | Cell phone: | E-mail: |
| Employer: | Employer Address and telephone no.: | |
| | | |

## IN CASE OF EMERGENCY

| | |
|---|---|
| Name of local friend or relative: | |
| Relationship to patient: | Date: |

**Assignment of Benefit**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Peter D'Aloia, D.D.S.. I understand that I am financially responsible for any balance. I also authorize Peter D'Aloia, D.D.S. or insurance company to release any information required to process my claims.

A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws will be charged on the unpaid principle balance on all accounts not paid within 60 days of treatment date.

| | |
|---|---|
| Signature of patient or (Representative/Guardian): | |
| Relationship to patient: | Date: |