MARINI & MANCI DENTISTRY
COSMETIC ■ IMPLANT ■ RESTORATION

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Dr. Joseph S. Marini
Dr. Gary M. Manci

WELCOME

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

PATIENT INFORMATION *Confidential*

Today's Date _____ **E-Mail Address** _____

Name _____ **Birthdate** _____
First MI Last

Address _____

Social Security # _____ **Telephone # (H)** _____ **(W)** _____

Mobile Phone # _____ **Do you prefer to receive calls at:** ☐ **Home** ☐ **Work** ☐ **Mobile**

Are you: ☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Your/Spouse's/Parent's employer _____ **Occupation** _____

Business Address _____

Spouse's/Parent's name _____ **Work Phone #** _____

If you are a student, name of school _____ **Address** _____

Who may we thank for referring you to our office? _____

Person to contact in an emergency _____ **Phone #** _____

RESPONSIBLE PARTY

Name of person responsible for the account _____ **SS #** _____

Relationship to patient _____ **Home Phone #** _____

Address _____

Name of employer _____ **Work Phone #** _____

INSURANCE INFORMATION

Name of insured _____ **Relationship to patient** _____

Name of employer _____ **Work Phone #** _____

Birthdate _____ **Social Security #** _____

Insurance Company _____ **Group #** _____

INSURANCE: We will bill your insurance company as a COURTESY TO YOU. We will assist in all necessary claims submissions in order to obtain payment for your dental services. You are expected to pay your portion of treatment at the time of service. Your insurance carrier's financial responsibility and your co-payment are only estimates. Anything not covered by your insurance company will be billed to you and payable upon receipt.

Remember the ultimate responsibility for payment is yours.

(Please complete other side.)