MICHAEL C. CORDORA DDS, PLLC

PATIENT INFORMATION

Today's Date_____

SSN_____

Patient Name_____(Last)

_____(First)_____(MI)

Address_____

City_____

State_____ Zip_____

Birthdate_____ Age_____

Married_____ Single_____

Minor_____ Other_____

Email Address_____

Employer/School_____

Occupation_____

Employer Phone_____

Spouse's Name_____

Spouse's Employer_____

****Whom may we thank for referring you?****

_____

Is patient covered by dental insurance?_____

Subscriber's Name_____

DOB_____SSN_____

Relationship to patient_____

Insurance Co._____

Group #_____

Insurance CO. Phone#_____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have insurance coverage with the following company_____, and assign directly to Dr. Cordora all insurance benefits that are payable to me for services. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, or Guardian

_____

Printed Name

_____

FINANCIAL INFORMATION

PHONE NUMBERS

Home#_____ Cell#_____ Work # _____

Best time and number to reach you_____

IN CASE OF AN EMERGENCY PLEASE CONTACT (Someone who does not live with you)

Name _____ Relationship_____ Phone #_____

REGISTRATION INFORMATION