
**The Office of Anthony DiNapoli DDS**

**Patient's Name:** _____
Last First Middle Nickname

**Address:** _____
Street City State Zip

**Tel: (H)**_____**(W)**_____**(C)**_____

**Email Address:** _____

**Birth Date:**_____**Social Security #:**_____

**Employer:** _____ **Phone:**_____

**Name of Spouse or Parent** (Please Circle One): _____

**Birth Date:**_____**Social Security #:**_____

**Whom may we thank for referring you to our office?** _____

**Please indicate your method of payment for your dental treatment:** (circle below)

**Cash** **Credit Card** **Check** **Dental Insurance**

**Primary Dental Insurance Company:**_____

**Insured Name:**_____**Social Security #:**_____

**Secondary Insurance Company:** _____

**Insured Name:**_____**Social Security #:** _____

**I understand that I am financially responsible for all charges for services rendered, regardless of insurance coverage. I understand that I will be expected to make payment at time services are rendered unless other arrangements have been previously made.**

**I authorize payment of dental benefits to the name provided above for professional services rendered. I also authorize release of any necessary medical/dental information to other health care providers or as needed to process insurance claims.**

**Signed:** _____ **Date:**_____