JOSEPH M. CATALANO, D.D.S., P.C.

Oral Surgery and Implantology

MEMBER A$A OMS Established 1918

PATIENT REGISTRATION

Date:_____ Name of General Dentist:_____ Referred By:_____

Name:_____ Soc. Sec. #:_____
Last Name First Name Initial

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ ❑ Cell Phone:_____ ❑ (check referral number) Student: Yes ❑ No ❑

Sex: Male ❑ Female ❑ Age:_____ Birth Date:_____ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑

Person Responsible for Account:_____ Patient Cell Phone:_____
Last Name First Name Initial

Employed By:_____ Occupation:_____

Employer's Address:_____ Work Phone:_____

Relationship to Patient: Self ❑ Spouse ❑ Other ❑ _____ Birth Date:_____ Soc. Sec. #:_____

PRIMARY INSURANCE (DENTAL)	PRIMARY INSURANCE (MEDICAL)
Subscriber:_____ (Last Name / First Name)	Subscriber:_____ (Last Name / First Name)
Address (if different from patient's):_____	Address (if different from patient's):_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Subscriber ID #:_____ Birth Date:_____	Subscriber ID #:_____ Birth Date:_____
Insurance Company:_____	Insurance Company:_____
Address:_____	Address:_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Group Name:_____ ID#:_____	Group Name:_____ ID#:_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? Yes ❑ No ❑

SECONDARY INSURANCE (DENTAL)	SECONDARY INSURANCE (MEDICAL)
Subscriber:_____ (Last Name / First Name)	Subscriber:_____ (Last Name / First Name)
Address (if different from patient's):_____	Address (if different from patient's):_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Subscriber ID #:_____ Birth Date:_____	Subscriber ID #:_____ Birth Date:_____
Insurance Company:_____	Insurance Company:_____
Address:_____	Address:_____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Group Name:_____ ID#:_____	Group Name:_____ ID#:_____

ASSIGNMENT and RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the following Insurance Company(ies):_____ _____, and assign directly to Joseph M. Catalano, D.D.S., P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that interest of 18% per year (1.5% per month) will be charged monthly on outstanding balances of all accounts that are delinquent and that each additional monthly statement will incur a $5.00 billing fee. I understand that I am responsible for any collection cost or attorney fees incurred in collecting a delinquent account as defined above.

_____

Responsible Party Signature Relationship Date