# JOSEPH M. CATALANO, D.D.S., P.C.
Oral Surgery and Implantology

## PATIENT REGISTRATION

DATE:_____ NAME OF GENERAL DENTIST:_____ REFERRED BY:_____

NAME:_____
FIRST NAME INITIAL LAST NAME

MAILING ADDRESS:_____ UNIT #:_____

CITY:_____ STATE:_____ ZIP:_____

PRIMARY PHONE NUMBER:_____ ❑ HOME ❑ CELL EMAIL:_____

SEX: ❑ MALE ❑ FEMALE AGE:_____ BIRTH DATE:_____ ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

PERSON RESPONSIBLE FOR ACCOUNT:_____ CELL PHONE:_____
FIRST NAME INITIAL LAST NAME

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ OTHER _____ BIRTH DATE:_____ SOC. SEC #:_____

EMPLOYED BY:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____ WORK PHONE:_____

### PRIMARY INSURANCE **(DENTAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ GROUP #:_____

CLAIMS ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

POLICY HOLDER:_____
(PRIMARY INSURED) FIRST NAME LAST NAME

BIRTH DATE:_____ SOC. SEC. #:_____

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____

CITY:_____ STATE:_____ ZIP:_____

### SECONDARY INSURANCE **(DENTAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ GROUP #:_____

CLAIMS ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

POLICY HOLDER:_____
(PRIMARY INSURED) FIRST NAME LAST NAME

BIRTH DATE:_____ SOC. SEC. #:_____

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____

CITY:_____ STATE:_____ ZIP:_____

### PRIMARY INSURANCE **(MEDICAL)**

INSURANCE COMPANY:_____

MEMBER ID:_____ GROUP #:_____ CITY:_____ STATE:_____ ZIP:_____

POLICY HOLDER:_____ BIRTH DATE:_____ SOC. SEC. #:_____
(PRIMARY INSURED) FIRST NAME LAST NAME

MAILING ADDRESS (IF DIFFERENT FROM PATIENTS):_____ CITY:_____ STATE:_____ ZIP:_____

PHARMACY NAME:_____ PHARMACY PHONE #:_____

### 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