

THOMAS G. VACCARO, D.D.S., P.C.

11130 Fairfax Blvd., Suite 201

Fairfax, Virginia 22030

(703) 591-1007

Today's Date _____

Patient Information (Confidential)

Full Name _____ Date of Birth _____ SSN _____
Address _____ City _____ Home Phone _____
State _____ Zip _____
Circle All That Apply: Minor Single Married Divorced Widowed Separated
If Student, Name of School _____ City _____ State _____ Full Time _____
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____
Address _____ Home Phone _____
Driver's License # _____ Date of Birth _____ Financial Institution _____
Employer _____ Work Phone _____ SSN _____
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured _____ Relationship _____
Date of Birth _____ SSN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship _____
Date of Birth _____ SSN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent if minor)