

Dominick C. Adornato III, D.D.S., Inc. Oral and Maxillofacial Surgery

1129 East Aurora Road, Suite 101 - Macedonia, Oh 44045
Phone #number 330-468-1188 <http://www.drtoothout.com>

All patient information must be printed and completely filled in

Today's Date _____

Patient Name _____

Soc. Sec. Number _____

Address Street _____

Date of Birth _____

City _____ State _____ Zip _____

College Student: YES NO If YES - enter school's name _____

Phone Numbers: **Home** (____) _____ **Cell** (____) _____ **Work** (____) _____

Emergency Contact Number (____) _____ Name _____ Relationship _____

Name of your Dentist _____ Phone Number (____) _____

Primary Dental Insurance Information - must be printed and completely filled in

Responsible Payee for Account _____ Date of Birth _____

Address (if different than patient's) Street _____

City _____ State _____ Zip _____ Soc. Sec. Number _____

Contact Numbers: **Home** (____) _____ **Cell** (____) _____ **Work** (____) _____

Dental Insurance Name _____ Phone Number (____) _____

Policy holder's name if different from responsible party _____

Policy Holder's Employer's Name _____

Dental Insurance ID number _____

How will payment be made today? (Please circle) CASH CHECK CREDIT CARD

***** Provide your insurance card at front desk with this completed form *****

Primary Medical Insurance Information - must be printed and completely filled in

Patient Name _____

Medical Insurance Name _____ Phone Number (____) _____

Policy holder's name if different from responsible party _____

Policy Holder's Employer's Name _____

Medical Insurance ID number _____

By signing this form, I am confirming the information provided is accurate and complete to the best of my knowledge. I understand this information will not be shared with anyone and will be used only in my treatment and for processing my insurance billing.

I will not hold Dominick C. Adornato III or his staff responsible for any errors or omissions I have made in the completion of this form.

Returned checks will carry a \$30.00 service charge. I understand my insurance is being processed as a courtesy by this office. I hereby guarantee payment in full for any charges not covered by my insurance for services rendered. I understand the deposit required on the day of surgery is only an estimate. Any remaining balance on my account after my insurance has paid becomes my obligation to pay.

Patient / Parent signature _____ Today's Date _____

If you carry secondary insurance coverage please provide complete policy information below and present to the front desk your secondary insurance card.

