LAFOND & TAMBINI, DMD, PA
PATIENT INFORMATION

Patient Name:_____Birthdate:_____ SSN*:_____ SEX: M F

Address: _____Lot# _____Apt#_____

City_____State_____Zip_____

Home#_____Cell#_____Work#_____

EMAIL ADDRESS:_____Employer:_____OR STUDENT

Who is your Regular Dentist? _____

Referred by (Circle one):Dr. _____ Dentist Family Friend Hospital Insur. Co. Phone Book

Have any of your family members been seen here before? If so whom/relation:_____

Emergency Contact:
Name_____Phone_____Relation_____

RESPONSIBLE PARTY: THIS IS NOT NECESSARILY THE POLICY HOLDER; THIS INDIVIDUAL SIGNS & ACCEPTS FINANCIAL RESPONSIBILITY. PARENT WHO BRINGS MINOR CHILD IN FOR TREATMENT IS THE RESPONSIBLE PARTY

Name_____Birthdate:_____SSN*:_____Relationship_____

Address:_____City_____State_____Zip_____

Home#_____Cell # _____WK:_____

***IF SSN IS NOT PROVIDED, OFFICE POLICY IS TO COLLECT IN FULL**

INSURANCE INFORMATION:

Primary Dental Insurance_____ Member ID#_____
Subscriber Name_____SSN#_____Birthdate:_____
Employer:_____ Group Id#_____

Secondary Dental Insurance_____ Member ID#_____
Subscriber Name_____SSN#_____Birthdate:_____
Employer:_____ Group Id#_____

Primary Medical Insurance_____ Member ID#_____
Subscriber Name_____SSN#_____Birthdate:_____
Employer:_____ Group Id#_____

Secondary Medical Insurance_____ Member ID#_____
Subscriber Name_____SSN#_____Birthdate:_____
Employer:_____ Group Id#_____