



Sean M. Cerone, D.D.S., P.A.

Family, Cosmetic & Implant Dentistry

WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we will be happy to help.

1. Personal Information

Date _____
Birthdate _____
SS#/SIN _____ Email _____
Name _____
Wishes to be called _____
 Male Female Minor Single Married Divorced Widowed Separated
Address _____
City _____ State/Province _____ Zip/P.C. _____
Employer _____ Occupation _____
Referred by _____

2. Responsible Party

Who is responsible for the account?
Name _____
Relationship to patient _____
Birthdate _____ Driver's License _____
SS#/SIN _____ Email _____
Address _____
City _____ State/Province _____ Zip/P.C. _____
Employer _____ Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____ Cell Phone _____

3. Telephone

Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____
Where do you prefer to receive calls? Home Work Cell
When is the best time to reach you? Time _____ Days _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Work Phone _____ Home # _____



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4. Dental Insurance Information

Primary Insurance

Additional Insurance

| | |
|-------------------------------|-------------------------------|
| Name of Insured _____ | Name of Insured _____ |
| Relationship to Patient _____ | Relationship to Patient _____ |
| Insured's Birthdate _____ | Insured's Birthdate _____ |
| SS#/SIN _____ | SS#/SIN _____ |
| Employer _____ | Employer _____ |
| Date Employed _____ | Date Employed _____ |
| Insurance Company _____ | Insurance Company _____ |
| Insurance Phone # _____ | Insurance Phone # _____ |
| Group # _____ | Group # _____ |
| Employee/Cert. # _____ | Employee/Cert. # _____ |
| Ins. Co. Address _____ | Ins. Co. Address _____ |
| Deductible _____ | Deductible _____ |
| Amount already used _____ | Amount already used _____ |
| Max. annual benefit _____ | Max. annual benefit _____ |

5. Authorization and Release

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 other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group 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/guardian if minor Date

6. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

- _____ Cash
- _____ Personal Check
- _____ Credit Card _____ Visa _____ MC
- _____ I wish to discuss the dental office's policy

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank You

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask -- we are always happy to help.