ANTHONY DINAPOLI, DDS, LLC

3158 East Broad Street
Columbus, Ohio 43209
Tel: 614.231.6872

784 East Main Street
Lancaster, Ohio 43130
Tel: 740.687.5811

Patient's Name: _____
Last First Middle Nickname

Address: _____
Street City State Zip

Tel: (H)_____ (W)_____ (C) _____

E-Mail Address: _____

Birth Date: _____ Social Security #: _____

Employer: _____ Address: _____

Name of Spouse (or Parent): _____

Birth Date: _____ Social Security #: _____

Employer: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Please indicate your method of payment for your dental treatment: (circle below)
cash credit card check dental insurance payment plan

Primary Dental Insurance Company: _____

Insured Name: _____ Social Security #: _____

Secondary Dental Insurance Company: _____

Insured Name: _____ Social Security #: _____

I understand that I am financially responsible for all charges for services rendered, regardless of insurance coverage. I understand that I will be expected to make payment at the time services are rendered unless other arrangements have been *previously* made. I understand that appointments that are cancelled without a 24 hour notice may be billed a cancellation fee.

I authorize payment of dental benefits to the names provided above for professional services rendered. I also authorize release of any necessary medical/dental information to other health care providers or as needed to process insurance claims.

Signed: _____ Date: _____