

Welcome to Drs. Genasci and Stigers's office. We sincerely appreciate you choosing our office for your dental needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Please tell us about yourself

Patient's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
e-Mail Address: _____
Who may we thank for referring you to us for care? _____

Today's Date: _____
Home Phone: _____
Date of Birth: _____ Sex: M F
Social Security #: _____
Do you have Dental Insurance? Yes No

If the Patient is a minor, please tell us about you, the parent or guardian:

Your Name: _____
Your Address: _____
City: _____ State: _____ Zip: _____

Relationship to Patient: _____
Your Home Phone #: _____
Your Social Security #: _____

Employer Information

Employer Name: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Business Phone: _____
Your position: _____
How long with company: _____

Spouse Information

Spouse's name: _____
Address: _____
Spouse's Employer: _____
City: _____ State: _____ Zip: _____

Spouse's Soc.Sec.. #: _____
Spouse's Date of Birth: _____
Business Phone: _____
How long with company: _____

Insurance Information

Name of Insurance Co: _____
Name of Insured Person: _____
Social Security # of Insured: _____

Plan Name or Number: _____
Group No./ Effective Date: _____
Insured Date of Birth: _____

AUTHORIZATION for TREATMENT: This is to certify that I, the undersigned Patient or Guardian, consent to all medical procedures agreed to between myself and Genasci and Stigers Family Dentistry, including the use of local, inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibility for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Genasci and Stigers Family Dentistry, at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

Patient's (Guardian's) Signature

Date