Cirelli Family Dentistry
Patient Update Information

Patient Name:____ Today's date:______________
Date of Birth: __/__/__ Age:____ Sex: M/F Marital Status ____ Social Security #____________
Address:______________________ Apt. #:_____ City: __________ State:______ Zip:_______
Mailing Address:________________ Apt. #:_____ City: __________ State: _____ Zip: _______
Home Phone: _________________Cell Phone:_______________ Work Phone:____________
Email Address:_______________Who may we thank for referring you?__________________
Employer: __________________ Employer Phone: _______________ Occupation: _________
How would you like to receive appointment reminders? Email_____ Text_____ Phone _____
Emergency contact: Name/Relationship:_______________________ Phone Number _________

Medical Update Information

Since your last exam have you:____
Had surgery/been hospitalized? ____
Started any new medications?____
Had any allergic reactions to medication?____
Had any changes in your medical/dental history?____
Any other medical information that Dr. Cirelli should be made aware of?

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Dental Insurance Information

PRIMARY INSURANCE
Insured's Name:____________________ Date of Birth: __/__/__ Social Security #: _________
Insured's Employer: __________________________ Insurance Company: _________________
Insurance Address: ___________________________ Insurance Phone: __________________
Insurance I.D. #:___________________________ Group # : ___________________________
SECONDARY INSURANCE
Insured's Name:____________________ Date of Birth:__/__/__ Social Security #:__________
Insured's Employer: __________________________Insurance Company: _________________
Insurance Address: ___________________________ Insurance Phone: __________________
Insurance I.D. #: ____________________________ Group#: ___________________________

Consent

The undersigned hereby authorizes Cirelli Family Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and examination of the patient's needs. I authorize Marc A. Cirelli, DMD, to perform any and all forms of treatment, prescribe medication or therapy that may be indicated. I understand the

use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance company and Cirelli Family Dentistry and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I assign all insurance benefits to Cirelli Family Dentistry. Any payments received by Cirelli Family Dentistry from my insurance coverage will be credited to my account, or refunded to me if I have paid all dental fees incurred. I further understand that a late charge will be added to any past due balances. In understand that where appropriate, credit reports may be obtained.

Patient Signature — Date

Guardian Signature — Date