Philip J. Pandolfi, D.M.D., PLLC

Patient's Name: ___________________________________

Medical Insurance
Company name: ___________________________________
Policyholder's name: _______________________________
Policyholder's birthdate: _____________________________
Policyholder's SSN: _______-________-_________
I.D. #: ____________________

Dental Insurance
Company name: ___________________________________
Policyholder's name: _______________________________
Policyholder's birthdate: ____________________________
Policyholder's SSN: _______-________-_________
I.D. #: ___________________

Person responsible for bill: ___________________________
Relationship to patient: _______________________
Address: ____

Complete the following if **parent** is financially responsible
Father's name: ________________________________
Father's employer: ____________________ Phone #: ___________

Mother's name: _______________________________
Mother's employer: ___________________ Phone #: ___________

"I request that payment of authorized benefits be made on my behalf to Dr. Philip J. Pandolfi for any services furnished me by that physician/provider. I authorize the release of any medical or dental information necessary to process this claim. I acknowledge my responsibility to pay for services not covered by my insurance company."

_______________________________________ _______________
Signature of responsible party Date