Additional Patients Not listed on the front.

Last First MI Nickname

Address SS # DOB

City ST Zip Sex Marital Status

Home # Work # Relationship to # 1 above

Cell # Alt. # Relationship to # 2 above

Last First MI Nickname

Address SS # DOB

City ST Zip Sex Marital Status

Home # Work # Relationship to # 1 above

Cell # Alt. # Relationship to # 2 above

Consent for treatment of minors If any listed patients are under 18 years old.

I, , being the parent or guardian of patients listed above, do hereby request and authorize Dr. Gazzerro and staff to perform any necessary dental services for my child deemed advisable by Dr. Gazzerro, whether or not I am present at the actual appointment when treatment is rendered.

Signature _____ Date

Release of information To file insurance and affirm your financial responsibilities.

I authorize Dr. Gazzerro to release any information necessary to secure payment of insurance benefits. I assign directly to Dr. Gazzerro all benefits, if any, otherwise payable to me. I understand that I am financially responsible for all charges incurred regardless of coverage by insurance. I also understand that I am responsible for charges incurred to collect payment.

Signature _____ Date

Acknowledgment of receipt of privacy practices

I have received a copy of Dr. Gazzerro's Notice of Privacy Practices. If there is anyone you would like to allow access to confidential information such as parent or spouse, please write their names here.

Signature _____ Date