ARELIS RODRIGUEZ-VIERA DMD, P.A.
2883 SOUTH DELANEY AVENUE
ORLANDO FLORIDA 32806

NEW PATIENT INFORMATION FORM

LAST NAME: ______________ **FIRSTNAME:** ________________ **MIDDLENAME:** ____________

HOME ADDRESS: ____

CITY ____________________________ **ZIP CODE** ____________________________________

HOME PHONE: __________________________ **CELL PHONE:** ____________________________

PATIENTS SS#: ______-______-______ **DOB:** ____/____/____ **Age** ________ **SEX:** _________

MEDICAL ALERTS: ____

PARENTS INFORMATION IS REQUIRED

NAME: ____

PARENTS SS#: ______-______-______ **DOB:** ______/_______/_______ **Occupation:** _____________

EMERGENCY CONTACT NAME: ________________________________ **PHONE#:** ____________

EMPLOYER NAME: ____

POLICYHOLDER NAME: ____

INSURANCE COMPANY NAME: __________________________ **MCNA:** ____ **DENTA QUEST** ____

MEMBERS ID #: ________________ **GROUP #:** ______________

RESPONSIBLE PARTY FOR PATIENT:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Dr. Arelis Rodriguez-Viera I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims.

Signature: ____ **Date:** ____________________________