

Michael J. Gulotta DDS PLLC Family Dentistry

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Holtsville, NY 11742

631-696-3820

**Registration and Health History
Patient Information**

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____ Work Phone: _____

Male Female Birthdate: ____/____/____ SS#: ____/____/____

Single Married Widowed Separated Divorced

In case of emergency please contact: (name) _____

Phone: _____ Relationship: _____

Whom may we thank for referring you? _____

Dental Insurance Information

Name : _____ DOB: _____ SS#: ____/____/____

Address (if different from patient): _____

Insurance Company: _____ Group #: _____

Insurance Address and Phone #: _____

Member's Employer: _____

Employer Address and Phone # _____

Is patient covered by additional dental insurance? Yes No If yes:

Member's name and address: _____

DOB: ____/____/____ SS#: ____/____/____ Relationship to patient: _____

Insurance Company: _____ Group #: _____

Insurance Address and Phone #: _____

Member's Employer: _

ASSIGNMENT OF BENEFITS AND RELEASE: I the undersigned, certify that I (or my dependent) have insurance with

_____ and assign directly to Dr. Gulotta, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date