ARTURO F. MOSQUERA, D.M.D., M.S., P.A.
ORTHODONTICS
DENTOFACIAL ORTHOPEDICS
1245 GALLOWAY ROAD
(S.W. 87TH AVENUE)
MIAMI, FLORIDA 33174
(305) 264-3355

Today's Date_____

PATIENT INFORMATION:

Name _____ Nickname _____ Age _____
Full Address _____ Zip Code _____
Home # _____ # Years in Community ____ School _____
Referred by _____ Dentist _____ Grade _____

RESPONSIBLE PARTY:

Name _____ Relationship to Patient _____
Social Security # _____ Birthdate _____
Employer _____ Occupation _____
No. of Years Employed _____ Work Phone # _____
Is Patient Living With Both Parents? _____ If not, please explain _____
Name _____ Relationship to Patient _____
Social Security # _____ Birthdate _____
Employer _____ Occupation _____
No. of Years Employed _____ Work Phone # _____

INSURANCE INFORMATION:

Do you have insurance? _____ yes _____ No
Insured's Name _____ Insured's Social Security # _____
Insurance Company _____ Group # _____ Local # _____
Does your spouse have insurance? _____ Yes _____ No, if yes:
Insured's Name _____ Insured's Social Security # _____
Insurance Company _____ Group # _____ Local # _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any provider, any insurer or other organizations to release any information regarding the dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

_____
Signature Date

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorize payment directly to the below named dentist.

_____
Signature Date

I realize it may be appropriate to utilize a credit report in determining a payment plan.

_____
Signature