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____ Marital Status _________________________

Address____

Home #_______________________________ Work #_______________________ Birthdate__________

Nickname ______________________ Social Security # ___________________# Yrs. in Community_____

Former Address (if less than 3 years) ____

Employer ____________________________ Position________________________ Start Date_______

Spouse's Name ____ Birthdate___________________

Spouse's Employer____ Position____________________

Spouse's Social Security #___________________________ Work #_____________ Start Date________

Referred By_______________________________ Dentist_____________________________

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