Andrew Ronan, D.M.D. LLC 148 East Avenue, Suite 3J, Norwalk, CT 06851 203.866.0415 F 203-354-9561

Getting Acquainted

Patient Information Please provide copy of patient's or guarantor's driver's license

Patient Name_____ Today's Date_____

Address_____ Apt_____

City_____State_____ Zip Code_____

Social Security #_____-_____-_____ Date of Birth_____

Employer _____Occupation_____

Whom may we thank for referring you?_____

Contact Information

Home (_____)_____Work(_____)_____ext._____

Cell (_____)_____E-mail_____

****We confirm appointments and send statements electronically. Do you prefer: text email both (please circle)

Emergency Contact Information

Name_____ Relationship_____

Home (_____)_____ Work (_____)_____ Cell (_____)_____

Primary Insurance Please provide copy of insurance card * *** Relationship to Patient_____

Subscriber's Name_____ Date of Birth_____

Social Security #_____-_____-_____ Insurance ID#_____

Insurance Company_____Group#_____

Employer_____

Secondary Insurance Please provide copy of insurance card * *** Relationship to Patient_____

Subscriber's Name_____ Date of Birth_____

Social Security #_____-_____-_____ Insurance ID#_____

Insurance Company_____Group#_____

Employer_____

Account Guarantor & Insurance Assignment & Release

I am responsible for all charges for services rendered, regardless of insurance coverage, if any. I give permission to send and receive correspondence, including dental records and financial records, electronically. In the event of default, I am responsible for all collections costs, court costs, and attorney fees required to collect the account balance. (Must sign if age 18 or older.)
For patients with insurance: I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for all charges for services rendered, regardless of insurance coverage. I authorize my insurance company to pay to Andrew Ronan, D.M.D. LLC all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the Dr. Andrew Ronan to release all information necessary to secure the payment of benefits. I agree to pay all deductibles and co-pays at the time of service.

Signature _____Date_____

Print Name _____Relationship to Patient_____

For your convenience, our office accepts cash, check, VISA, MC, AMEX, Discover and CareCredit.