Michael A. Izzo, D.D.S. P.C.
1310 Warwick • Lincoln Park, MI 48146
Phone: (313) 386-7660

Patient Information

First Name _____ Last Name _____ M.I._____ Birthdate _____

Address _____ City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____ SS #_____

Check appropriate box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's or Parent / Guardian's Employer_____ Work Phone _____

Spouse or Parent/Guardian's Name _____ Employer_____ State _____ Zip_____

If patient is a student, name of school / college_____ City_____ State _____

Whom may we thank for referring you?_____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relation to patient _____

Address _____ Home Phone_____

Cell Phone_____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Insurance Information

Name of insured _____ Relation to patient _____

Address _____ Home Phone _____

Birthdate _____ SS # / SIN _____

Name of Employer_____ Work Phone_____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

Do you have any additional dental insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relation to patient _____

Birthdate _____ SS # / SIN _____

Name of Employer_____ Work Phone_____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

Release:

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I understand that I am responsible for all costs of dental treatment.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I attest to the accuracy of the information on this page.

_____ _____

Signature of Patient or Parent / Guardian if Minor Date