

Ross K. Palioca, D.M.D., P.C.
Advanced Dental Practices
21 East Street
Wrentham, MA 02093

Name _____

Address _____

City/Town: _____ State: _____ Zip Code _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email address: _____

Date of Birth: _____ Male: _____ Female: _____

Social Security Number (for insurance purposes): _____

Primary Dental Insurance: _____

Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

ID#: _____ Group#: _____

If Full-Time student, please list name and address of the college/university:

I understand that my dental insurance is a contract between the insurance carrier and me and **NOT** between the insurance carrier and the dentist. Therefore, I am still responsible for **ALL** dental fees. I understand that I will be charged for all dental treatment and that any payments received by the dental office from my insurance company will be credited to my account or refunded to me if I have paid for the treatment.

I agree to be responsible for all charges for dental services and materials not paid by my dental insurance plan, unless the treating dentist has a contractual agreement with my plan, prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signature: _____ Date: _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature: _____ Date: _____

Since I do not have dental insurance, I agree to be responsible for **ALL CHARGES** for dental services and materials.

Signature: _____ Date: _____