Dr. Glenn Giamo
935 Trancas St. Suite 5B
Napa, California 94558

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____ (FIRST MI LAST) Patient # _____

SS# _____ ❑ Male ❑ Female Birthdate _____ Home phone _____

Address _____ City _____ State _____ Zip _____

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

Patient's or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

If patient is a student, name of school/college _____

❑ Part time ❑ Full time City _____ State _____

Whom may we thank for referring you? _____

Relative to contact in case of emergency _____ Phone _____

Responsible Party

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

Address _____ Home phone _____

Driver's license # _____ Birthday _____ Financial institution _____

Employer _____ Work phone _____

Is this person currently a patient at our office? ❑ Yes ❑ No

Insurance Information

Name of person carrying insurance _____ Relationship to patient _____

Birthday _____ Social Security Number _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

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

Name of other person carrying insurance _____ Relationship to patient _____

Birthday _____ Social Security Number _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. Co. address _____ City _____ State _____ Zip _____

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.
PLEASE REMEMBER INSURANCE BENEFITS ARE A CONTRACT BETWEEN THE PATIENT AND SAID INSURANCE COMPANY, NOT THE DENTIST AND SAID INSURANCE COMPANY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED. THANK YOU.

X _____ _____

Signature of patient or parent if minor — Date