Patrick MAZZEI DDS
Patient-first care that revolves around you

6335 N. Fresno St., Suite / Suite 104 / Fresno, CA 93710 / 559-432-6474

PATIENT DATA		
Name		Date of Birth
Marital Status/Minor?		Social Security No.
Address/City/Zip		Email Address
Home Phone	Cell Phone	Work Phone
In case of emergency notify:		Referred by:
PARTY RESPONSIBLE FOR PAYMENT - If different from above		
Name		Date of Birth
Relationship to Patient?		Social Security No.
Address/City/Zip		Email Address
Home Phone	Cell Phone	Work Phone
PRIMARY INSURANCE		
Subscriber		Date of Birth
Group Name/Number		Social Security No.
SECONDARY INSURANCE		
Subscriber		Date of Birth
Group Name/Number		Social Security No.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize Patrick Mazzei, D.D.S. to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize the release of any information concerning my/my minor child's health care, advice and treatment to another dentist and/or physician.

I understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that Patrick Mazzei, D.D.S. will file my insurance claim(s) for benefits in good faith. To the extent permitted under applicable law, I hereby authorize release of ay information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Patrick Mazzei, D.D.S. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to Patrick Mazzei, D.D.S. for any services rendered to me or my dependents as if I had signed each benefit assignment of future claims.

I understand payment for services (or patient's portion if insured) is due at time of treatment payable by cash, check, VISA, MasterCard, Discover Card or ATM. Also, upon additional agreement, treatment can be financed through CareCredit® or Citi Health Card.

In the event I do not pay my account balance within 90 days, I understand that a 2% per month late fee (or $2 per month minimum late fee), 24% annual maximum, may be added to my account, in addition to any collection charges. I understand that when appropriate, credit bureau reports may be obtained.

I understand that it is my responsibility to advise Patrick Mazzei, D.D.S. of any changes in the information obtained on this form. I hereby attest to the accuracy of this information on this questionnaire. This "Signature on File" will be valid from this date and shall expire in 3 (three) years.

Today's Date	Signature
Expiration Date	Witnessed by