THOMAS G. VACCARO, D.D.S., P.C.
11130 Fairfax Blvd., Suite 201
Fairfax, Virginia 22030
(703) 591-1007

Today's Date_____

Patient Information *(Confidential)* SSN_____

Full Name_____ Date of Birth_____ Home Phone_____
Address_____ City_____ State_____ Zip_____
Circle All That Apply: Minor Single Married Divorced Widowed Separated
If Student, Name of School_____ City_____ State_____ Full Time_____
Patient's or Parent's Employer_____ Work Phone_____
Business Address_____ City_____ State_____ Zip_____
Spouse or Parent's Name_____ Employer_____ Work Phone_____
Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship_____
Address_____ Home Phone_____
Driver's License #_____ Date of Birth_____ Financial Institution_____
Employer_____ Work Phone_____ SSN_____
Is this Person Currently a Patient in our Office? Yes No

Insurance Information

Name of Insured_____ Relationship_____
Date of Birth_____ SSN_____ Date Employed_____
Name of Employer_____ Union or Local#_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group#_____ Policy/ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship_____
Date of Birth_____ SSN_____ Date Employed_____
Name of Employer_____ Union or Local#_____ Work Phone_____
Address of Employer_____ City_____ State_____ Zip_____
Insurance Company_____ Group#_____ Policy/ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of patient (or parent if minor)