

Dr. Gene DeStefano

DeStefanoDental.com

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(845)331-7089

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: _____

Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Name of Responsible Party/Guarantor:

Relationship to Guarantor:
 Self Spouse Parent Authorized Guardian

Who May We Thank For Referring You?

Primary- Dental Insurance Information:

Yes No

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Secondary-Dental Insurance Information:

Yes No

Name of Insured: _____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

For your convenience, we offer the following methods of payment. Please check the option you prefer:

Cash Personal Check Charge: MC/Visa/Amex/Discover/Care Credit

Response Date: _____