Andrew Gazerro, D.M.D.
1425 Main Street
West Warwick, RI 02893

Rediscover Your Smile

Patient Information

Name: Last, First, M.I.					Referred by:
Date of Birth	Social Security No.	Male	Female		Spouse's Name
Address-- Please include the	City, State, Zip				Telephone Day
Change of Address					Cell Phone
Signature of Parent/Guardian			E-Mail Address		Telephone Work
Name of Parent/Guardian					
Your Occupation	Employer/Business Address				

* Cell phone numbers and e-mail addresses are necessary for our automated appointment confirmation system.

Method of Payment

Please note that you will be responsible for any fees not covered by your insurance.

Self pay with insurance	
Self pay without insurance	

Dental Insurance Data

Proof of insurance is not a guarantee of payment. YOU are responsible for all charges.

Insurance Company (Primary)		Identification Number	
Name of Insured Person	Date of Birth	Relationship to Patient Self Spouse Parent	Insured's Employer
Insurance Company (Secondary)		Identification Number	
Name of Insured Person	Date of Birth	Relationship to Patient Self Spouse Parent	Insured's Employer

I hereby authorize the doctor or members of his staff to perform an examination of my mouth, teeth, and related structures. This examination will include an interview regarding my medical history and present health, a physical examination of my mouth, teeth, and related tissues and structures, and X-rays of my teeth and jaws. Additional laboratory and other diagnostic tests may be advised. I understand that all examination procedures will be explained to me before they are performed. I understand that my treatment needs and a plan of treatment will be determined by this examination. I understand that my treatment needs and a plan of treatment will be presented to me and that no treatment will be performed until I have given my consent. I also understand that if the doctor or a member of his staff is accidentally exposed to my blood during exam or treatment, I may be required to have a blood test, at no expense to me, to verify I have no infectious diseases.

Signature of Patient/Parent/Guardian	Signature of Witness	Date