Garden City Smiles

Dr. Louis J. Buono
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Garden City, N.Y. 11530
(516) 294-0375 www.GardenCitySmiles.com

Patient's Name: _____ **Date of Birth:** _____

( ) Male ( ) Female **( ) single ( ) married ( ) divorced ( ) widowed**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home#_____ **Cell#** _____ **Work#**_____

Social Security #: _____-_____-_____ **Drivers License State:**_____ **I.D.#:**_____

Email Address:_____

Purpose of this appointment: _____

In case of an emergency, who should be notified: _____ **Phone#:** _____

Patient Employer: _____ **Present Position:**_____

Business Address: _____

Whom may we thank for referring you: _____

May we send you our "Like Page" on Facebook?____ **Account Name:**_____

Spouse/Partner or Guardian (if child is under age 18):

Name:_____ **Date of Birth:** _____

Social Security #: _____-_____-_____ **Drivers License State:** _____ **I.D.#**_____

Telephone#: _____ **Employer Name:** _____

Business Address: _____

*Insurance Information:

Insurance is a contract between you and your insurance company. We will submit forms to your insurance company as a courtesy to you, but we request that you pay your estimated portion when services are rendered.

Primary Insurance* : **Subscriber Name**_____ **DOB** _____
Insurance Carrier:_____ **Subscriber ID#**_____ **Group#**_____
Secondary Insurance* : **Subscriber Name**_____ **DOB** _____
Insurance Carrier:_____ **Subscriber ID#**_____ **Group#**_____

I, the undersigned certify that I (or my dependent) have insurance coverage with the above listed company and assign directly to Dr. Buono all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.

***Signature:** _____

Optional: Any unpaid balance(s) are authorized to be automatically billed to the following:
If using charge card, Name: _____ **Card#** _____ **Exp.date:** _____

Patient Signature: _____ **Date:** _____

(If patient is under age 18, Parent/Guardian Signature Required)