GARDEN CITY CENTER
FOR DENTAL EXCELLENCE

James J. Fitzgerald D.D.S., P.C.
Danielle M. DiVanna D.D.S.
Junaid Rajani, D.D.S.

PATIENT INFORMATION

Name:_____Date of Birth:_____

Address:_____
Street City State Zip

Home Phone:_____Work Phone:_____

Cell Phone:_____Email:_____

Social Securtiy #:_____Marital Status:_____

Emergency Contact Name:_____#_____

Whom may we thank for referring you?_____

_____Dental Insurance Information_____

Insurance Carrier:_____

Employer:_____

Name of Policy holder: _____DOB:_____

Group #:_____SSN/ID#:_____

We will submit all insurance claims with the understanding you will be responsible for any non-covered procedures or difference in fees based on procedure completed.

Signature:_____Date:_____

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