



**Amul Patel D.D.S., P.C**

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**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_/\_\_\_/\_\_\_ **Appointment Date:** \_\_\_/\_\_\_/\_\_\_ **Time** \_\_\_\_\_:

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home/Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_ @ \_\_\_\_\_

Address: \_\_\_\_\_ Apt \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Referred By: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Pharmacy# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Address \_\_\_\_\_ Employer \_\_\_\_\_

Policy Holder \_\_\_\_\_ D.O.B \_\_\_\_\_ Policy Holder Relationship \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

In Network/Out of Network Based on calender Year/Other? \_\_\_\_\_ Payer ID \_\_\_\_\_ Effective Date: \_\_\_\_\_

Circle One: Single/ Family Plan Annual Max : \$ \_\_\_\_\_ Used \$ \_\_\_\_\_ Deductible Individual \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

FMX Freq \_\_\_\_\_ Years Last FMX \_\_\_\_\_ Propy Freq \_\_\_\_\_ BWX Freq \_\_\_\_\_ Exam Freq \_\_\_\_\_

Waiting Period for Major Services Yes/No \_\_\_\_\_ Missing Tooth Clause \_\_\_\_\_

Preventive \_\_\_\_\_ % Basic \_\_\_\_\_ % Major \_\_\_\_\_ % Ortho \_\_\_\_\_ % Age Limit \_\_\_\_\_

Perio/Endo/Basic under Basic? Yes/No Ortho Max \$ \_\_\_\_\_ Ortho Deductible \$ \_\_\_\_\_ Traditional \_\_\_\_\_ Invisalgin \_\_\_\_\_

Root Planning & Scaling: Quad per visit \_\_\_\_\_ Frequency \_\_\_\_\_ Arestin (D4381) \_\_\_\_\_ Pocket size \_\_\_\_\_ How many per visit \_\_\_\_\_ r

Posterior Composite Covered (D2391) Freq \_\_\_\_\_ Prostheses (D5213) Freq \_\_\_\_\_

Full Cast Restoration (D2752) Freq \_\_\_\_\_ Emax Crown (D2740) \_\_\_\_\_ Emax Bridge (D6740) \_\_\_\_\_

Agent Name : \_\_\_\_\_ Staff Name: \_\_\_\_\_