

**PATIENT INFORMATION PROFILE**  
**TIMOTHY P. PASSARELLO, D.D.S.**

*Welcome! So that we may provide you with the best possible care please complete the first 3 pages of this form.  
All information is completely confidential.*

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
IF A CHILD, RESPONSIBLE PARTY'S NAME \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SOCIAL SECURITY NUMBER OF PATIENT \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
PATIENT EMPLOYED BY \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
\_\_\_\_\_  
DRIVER'S LICENSE NO. \_\_\_\_\_

**ACCOUNT INFORMATION**  
**PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT**

NAME \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE NO. \_\_\_\_\_ CELL PHONE NO. \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
BUSINESS PHONE NO. \_\_\_\_\_

**INSURANCE INFORMATION**  
**PRIMARY CARRIER**

INSURANCE COMPANY \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
EMPLOYEE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
UNION OR LOCAL NO. \_\_\_\_\_  
EMPLOYEE SOC. SEC. NO. \_\_\_\_\_

**SECONDARY CARRIER**

INSURANCE COMPANY \_\_\_\_\_  
GROUP NO. \_\_\_\_\_  
EMPLOYEE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
UNION OR LOCAL NO. \_\_\_\_\_  
EMPLOYEE SOC. SEC. NO. \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? \_\_\_\_\_ PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_