

# MAX & GATTA, P.L.L.C.

5455 North Federal Highway, Suite D  
Boca Raton, FL 33487-4994  
(561) 997-6622

## Acquaintance Form

Date: \_\_\_\_\_  
Married: \_\_\_\_\_ Single: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
Person Responsible for My Account: \_\_\_\_\_  
Whom May We Thank For This Referral: \_\_\_\_\_  
Email address: \_\_\_\_\_

### Dental Insurance Information:

Dental Insurance Company: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Policy Holder Birth Date: \_\_\_\_\_  
Policy Holder Social Security Number: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Holder Employer: \_\_\_\_\_

\*\*\* Insurance is not a form of payment in our office. Fees are due at the time services are rendered. We will be happy to file your claim form for you. We cannot render service on the assumption that the charge will be paid by your insurance company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_