Patient Information

Last Name: ________________________________ First Name: ________________________Mr./ Dr. / Mrs. / Miss / Ms.

Mailing Address: (Street, City, State, Zip)____

Birthday: _____/_____/____________ Male Female Single Married Widowed Divorced

Home Phone: _____________________ Work Phone: ______________________ Cell Phone: ______________________

Which number would you prefer we call? _________________________________

Email Address: ____ Do you want Email reminders? Yes No

Social Security Number: ____

Occupation: _____________________ Employer: _____________________ Employer Phone: _____________________

Where do you work? (Street, City, State, Zip) ____

How did you hear about our office? Best of Long Island Friend Sign Insurance Co. Website Other ______

In Case of Emergency, Contact

Name: ____ Relationship: _______________________________________

Home Phone: _____________________ Work Phone: ______________________ Cell Phone: ______________________

Dental Insurance Information

This coverage is through Spouse Parent Other ______________________

Their Last Name: ____________________________ Their First Name: ____________________________

Their Home Phone: ________________ Their Work Phone: __________________ Their Cell Phone:_________________

Their Social Security Number: ______________________ Their Birthday: ________________________

Their Occupation: ___________________ Employer: ___________________ Employer Phone: ______________________

Where do they work? (Street, City, State, Zip) ____

Insurance Company: ___________________________ Phone Number of Insurance Company: ___________________

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** _______________________________________ Date:______________________