

CNY PERIODONTICS AND IMPLANTS

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"WE BEST SERVE YOU IF THIS FORM IS COMPLETED THOROUGHLY"

NAME _____ TODAY'S DATE _____

MAILING ADDRESS _____

CELL PHONE (_____) _____ WORK _____ HOME _____

EMPLOYER _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ SEX _____ M _____ F HEIGHT _____ WEIGHT _____

EMAIL ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S SS# _____ SPOUSE'S EMPLOYER _____

NAME & # OF AN EMERGENCY CONTACT: _____

REFERRING DENTIST _____ SINCE _____

PHARMACY NAME/LOCATION _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____

POLICY HOLDER & EMPLOYER _____

SUBSCRIBER ID/GROUP # _____

SECONDARY INSURANCE _____

POLICY HOLDER, EMPLOYER & ID # _____

ASSIGNMENT AND RELEASE

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. THE ABOVE-NAMED PHYSICIAN MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____

PLEASE PRINT NAME OF PATIENT _____ RELATIONSHIP TO PATIENT _____