

## Patient Information

Patient \_\_\_\_\_ Today's date \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Last First MI Preferred name  
\_\_\_Mr. \_\_\_Mrs. \_\_\_Ms. \_\_\_Dr. \_\_\_Male \_\_\_Female \_\_\_Married \_\_\_Single \_\_\_Minor \_\_\_Other:

Address \_\_\_\_\_  
Street City State Zip Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_/\_\_\_/\_\_\_

Phone #s Home: (\_\_\_\_) \_\_\_\_\_ Office: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_  
e-mail Address \_\_\_\_\_

Whose name shall appear as the  
Account Responsible Party? \_\_\_\_\_

\_\_\_\_\_  
Last First MI  
\_\_\_Self \_\_\_Spouse \_\_\_Parent or Guardian \_\_\_Other:

If not "Self": Address \_\_\_\_\_  
Street City State Zip Code

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_/\_\_\_/\_\_\_  
Phone #s (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

## Employment & Dental Insurance

Employer \_\_\_\_\_ Address & Phone # \_\_\_\_\_ (\_\_\_\_)  
Street City State/Zip Code Phone #

Subscriber's Name \_\_\_\_\_ Is subscriber a patient? \_\_\_yes \_\_\_no  
Last First MI

Relationship to patient \_\_\_Self \_\_\_Spouse \_\_\_Parent or Guardian \_\_\_Other:

Subscriber's Address \_\_\_\_\_  
Street City State Zip Code

Subscriber's: Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_/\_\_\_/\_\_\_

Insurance Plan \_\_\_\_\_ Group Policy # \_\_\_\_\_

Claims Address \_\_\_\_\_  
Street or P.O. Box# City State Zip Code

If Secondary Insurance: Employer \_\_\_\_\_ Address & Phone # \_\_\_\_\_ (\_\_\_\_)  
Street City State/Zip Code Phone #

Subscriber's Name \_\_\_\_\_ Is subscriber a patient? \_\_\_yes \_\_\_no  
Last First MI

Relationship to patient \_\_\_Self \_\_\_Spouse \_\_\_Parent or Guardian \_\_\_Other:

Insurance Plan \_\_\_\_\_ Group Policy # \_\_\_\_\_

Claims Address \_\_\_\_\_  
Street or P.O. Box# City State Zip Code

## Financial Responsibility & Assignment of Benefits

The Insurance benefit is the patient's responsibility. We will assist you in obtaining these benefits, but the ultimate financial obligation lies with the patient.

\_\_\_\_\_ assigns all insurance payments to Dr. Laurence M. Brownstein, Lic#33728, for all dental treatment rendered.  
Subscriber's name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date