CHARLES FELDMAN, D.D.S. **Date:**_______________

Were you referred by one of our Patients?
☐ Yes, Whom may we thank? ____________________
☐ No, How did you find us? ____________________

Patient Information

Patient's Name: ____________________ Birth Date__________ Sex: M / F
Address: ____________________ City__________ St. _____ Zip__________
Home Phone: (___)__________Cell: (___)__________ E-Mail:__________
Social Security Number: ________-________-________ Driver's License #__________
Employer:____________________ Work Phone: (_____)__________
In case of emergency, who should we notify? ____________________
Relationship____________________ Phone No: (_____)__________

Insurance Information (responsible party)

Insurance Co.____________________ Group/Policy #: __________
Name of Employee ____________________
Social Security Number: ________-________-________Date of Birth: __________ Sex: M / F (circle one)
Employer Name: ____________________
Employer Address: ____________________
Patient's relationship to above employee: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which l am entitled

X____________________ **Date**__________

SIGNATURE **OF** PATIENT (or Signature of responsible party if patients is a minor)

Second Insurance Information (if applicable)

Insurance Co.____________________ Group/Policy #: __________
Name of Employee ____________________
Social Security Number: ________-________-________Date of Birth: __________ Sex: M / F (circle one)
Employer Name: ____________________
Employer Address: ____________________
Patient's relationship to above employee: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Acknowledgment of Receipt of Dental Material Fact Sheet and Notice of Privacy Practices

Dental Material Fact Sheet

I acknowledge that I have received a copy of the **Dental Material Fact Sheet Dated May 2004.**

Signature____________________

Date____________________

Notice of Privacy Practices

I acknowledge that I have received a copy of this office's **Notice of Privacy Practices.**

Signature____________________

Date____________________